United States Court of Appeals

for the

District of Columbia Circuit

TRANSCRIPT OF RECORD

992

BRIEF FOR APPELLANT

IN THE

UNITED STATES COURT OF APPEALS

FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 24010

ALTON A. JONES, JR.,

APPELLANT,

v.

LUTHER D. ROBINSON, M.D., Acting Superintendent,
St. Elizabeths Hospital
Washington, D. C.,

APPELLEE.

APPEAL FROM THE DISCHARGE OF WRIT OF
HABEAS CORPUS BY THE UNITED STATES
DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

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MISCELLANEOUS

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BRIEF FOR APPELLANT

STATEMENT OF QUESTIONS PRESENTED

1. Whether appellant is entitled to be released by appellee because he is no longer likely to be dangerous to himself or others by reason of mental illness.

2. Whether appellant is entitled to be released by appellee where appellee's staff psychiatrists all concede that appellant is no longer suffering from the

mental illness on the basis of which he was committed to the Hospital.

3. Whether appellant's confinement violates due process and equal protection where he was committed without any finding of dangerousness by reason of mental illness at the time of commitment.

4. Whether appellant is entitled to release from the Hospital because he is not receiving adequate treatment.

5. Whether appellant was denied due process of law when he was summarily transferred to the John Howard Pavilion, the maximum security unit in the Hospital, in 1967.

6. Whether appellant is improperly confined in John Howard Pavilion, where such confinement is not required by treatment or security considerations.

This case has not previously been before this Court.

REFERENCES TO RULINGS

On January 29, 1970, the district judge entered herein Findings of Fact and Conclusions of Law and an Order.

STATEMENT OF THE CASE

Introduction

Appellant Alton Jones was committed to St. Elizabeths Hospital in 1960 and recommitted, pursuant to D.C. Code §24-301(d), in 1963. (Transcript of the Habeas Corpus Hearing in District Court, December 22-23, 1969, p.74 [hereinafter cited as Tr.]; Habeas Corpus petition ¶2.) On September 22, 1969, he filed a petition for writ of habeas corpus in District Court, alleging that he was entitled to be released from the Hospital because he had recovered his sanity and was no longer dangerous to himself or others by reason of an abnormal mental condition and because the Superintendent of the Hospital had no legal right to continue to detain him. In elaborating on the illegality of his continued detention, at the hearing appellant alleged that his first commitment was legally invalid and that he was no longer suffering from the mental illness, schizophrenia, from which he was suffering at the time of his commitment. (Tr.3-4)

In the alternative, if he were not found eligible for release, appellant claimed in his petition that he was entitled to be transferred out of John Howard Pavilion ("John Howard"), the maximum security facility. He contended that the maximum security facility at St. Elizabeths Hospital ("the Hospital")

was not an appropriate place of confinement for him, in terms of treatment or security requirements. (Tr.4) Appellant further alleged that the Hospital's fact-finding procedures in connection with the incident which led to his most recent return to John Howard in 1967 were legally inadequate, and the Superintendent's denials,without explanation, of several recommendations made by his doctors for appellant's transfer out of John Howard were arbitrary and illegal.

Appellant's Progress in the Hospital

Appellant, who is now 47 years old, was first committed to St. Elizabeths Hospital in 1960. (Tr. 71) He was recommitted in 1963 after a finding that he was not guilty by reason of insanity on two counts of carnal knowledge and sodomy, charges growing out of his rape of his eleven-year-old niece. (Tr. 74) He was diagnosed by the Hospital staff at the time as suffering from schizophrenic reaction, chronic undifferentiated type. (Tr. 39, 144)

During the course of appellant's stay at the Hospital, his behavior and attitudes improved dramatically. The turning point occurred in 1965. (Tr. 46-47; Petitioner's Exhibit 1, Recommendation for conditional release, December 8, 1969; Recommendation for Transfer, June 7, 1966; Note, October 20, 1965; Petitioner's Exhibit 1, the Hospital file containing periodic notes entered by psychiatrists, is hereinafter referred to as Pet. Ex. 1.) Illiterate when he entered the

Hospital, appellant learned to read and write proficiently. (Tr. 45-46, 117) The Director of Education in John Howard stated:

> "...his school behavior is somewhat remarkable. Mr. Jones [appellant] ranked first among all patients participating in the educational program in a sincere desire for education and self-improvement in the pursuit of knowledge. His academic behavior was excellent...His previous academic impoverishment was, of course, a handicap but he worked hard to overcome it." (Tr. 45-46; Pet. Ex. 1, Note of Mr. Corban, April 8, 1965.)

Mr. Corban later stated, "Mr. Jones is the patient most sincerely interested in acquiring further knowledge and furthering his educational level that this writer has ever seen." Pet. Ex. 1, Note of Mr. Corban, August 8, 1966.

Petitioner also learned the tailoring trade in the Hospital and began to make clothes for his sister-in-law and her children. (Tr. 102) The Occupational Therapy Supervisor noted that appellant "sustained his interest in tailoring, doing excellent work and quickly learning all areas of the trade." (Tr. 46; Pet. Ex. 1, Note of Mr. Henry Herzog, June 3, 1969.)

With regard to the crime of which he was found not guilty by reason of insanity, appellant developed deep feelings of shame and self-disgust. (Tr. 132) Dr. Harold Kaufman, his ward administrator, testified as to the sincerity of appellant's remorse and sense of moral responsibility. (Tr. 75)

The testimony at the hearing focussed on the period since 1965, during which time appellant has been almost

continuously in John Howard. His conduct in John Howard during these five years has been good, free from incidents of violence or poor control over himself. The nursing assistants consider him an excellent patient, (Tr. 65) and he has been a problem to no one. (Pet. Ex. 1, Periodic Treatment Review, July 30, 1969.) His diligent efforts to improve himself and his constructive efforts to work toward release were noted by psychiatrists and other staff. (Pet. Ex. 1, Recommendation for Transfer, July 29, 1968; Notes, April 5, 1967, August 8, 1966; Tr. 65.)

In December, 1966, appellant was transferred to the Cruvant Division, a medium-security facility, as part of a program of increasing appellant's privileges, gradually leading to release. (Pet. Ex. 1, Note, December 20, 1966.) His behavior continued to be excellent, and he was gradually, over five months, granted increased privileges. (Tr. 48, 192-93; Pet. Ex. 1, Recommendations, January 4, 1967, March 2, 1967, April 5, 1967.)

Accusations growing out of an incident with his girl friend in May, 1967, led to his transfer back to John Howard, where he has remained since. (Tr. 16, 18, 51) There is only one sworn first-person account of the incident, and that is appellant's. (Tr. 183) He testified that he and his girl friend, also a patient, met by arrangement, went to a scheduled place on the grounds, and had consensual intercourse. (Tr. 119, 123-24) She subsequently became upset, attacked appellant,

and a scuffle ensued. She calmed down and they went together for coffee in the Hospital canteen. (Tr. 125) Later, she apparently became upset again and reported the act as rape. (Tr. 17) Appellant was summarily transferred to John Howard; he was given no hearing and no opportunity to confront the girl. (Tr. 138) The Hospital did not investigate the girl's charges either before or after appellant's transfer (Tr. 50-51, 91-93) nor did they check appellant's story, some elements of which, such as the visit to the canteen with the girl after the incident, could easily have been verified.[1/]

Recommendations for Release and Transfer

As noted above,appellant has, since 1965, learned tailoring skills, broadened his intellectual horizons (Tr. 117), and his behavior has totally changed. He has become introspective, and has been able to analyze and evaluate his past actions. He is confident about his ability to control himself and to lead a productive life outside the Hospital. (Tr. 121)

Appellant's doctors, responding to these changes, have repeatedly recommended transfer to a less secure service. In

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1/ The doctor who was in charge of the girl at the time believed that the girl consented to intercourse, but that appellant had taken advantage of a girl with a low I.Q. (Tr. 126-27) Further, the treating physician felt that such behavior justified immediate return to John Howard. (Tr. 49-50, 91-92)

Dr. Daniel Pugh, a physician who was not at the Hospital when the incident occurred and who had nothing to do with it, believes that appellant committed forcible rape on the girl. (Tr. 181-182)

July, 1968, all the psychiatrists in John Howard with responsibility for the matter concurred in a recommendation for transfer. (The Recommendation for Transfer, July 29, 1968 is attached hereto as Appendix A. See Tr. 51, 119-20) This recommendation was denied without explanation by the Hospital Superintendent. (Tr. 51-52, 120) There was a repetition of this sequence of events in March, 1969, when Dr. Hamman stated, in recommending transfer:

> "His behavior on the ward has been excellent in terms of cooperating with attendants and patients, in terms of his general demeanor, in terms of his attitude and in terms of the constructive nature of the activities in which he is involved, that is, he remains aloof from the cliques where manipulation and power struggle seems to be the prime objective. He definitely wants to be transferred off service and seems to have been working very hard toward this goal for some time now." (Pet. Ex. 1, Recommendation for Transfer, March 10, 1969, attached hereto as Appendix B; Tr. 51)

Yet, once again, there was an unexplained denial of the recommendation by the Superintendent. (Tr. 51-52, 120-121)

Most recently, appellant was recommended by his ward administrator for conditional release from the Hospital. (The Recommendation for Release, December 8, 1969, is attached hereto as Appendix C. In the Recommendation, Dr. Kaufman noted: "The nursing attendants, who have known Mr. Jones, and the nurses agree with my assessment that Mr. Jones is not now likely to be dangerous to himself or others." (See Tr. 34-35)

Dr. Kaufman testified at the hearing that appellant has no mental illness. (Tr. 38-42) When asked by the court if he

thought appellant had any mental disease or defect, he said: "I am quite confident that he does not...the decision is a difficult one for me to make considering the fact that there is a great deal of responsibility inherent in it." (Tr. 42) Moreover, Dr. Kaufman testified that he believes that Mr. Jones "would not be likely to be dangerous to himself or others if released to the community." (Tr. 36)

Dr. Kaufman testified that continued confinement in John Howard would be anti-therapeutic for appellant:

> I think this is a very critical time at present for him to leave the hospital in view of the fact that he has a brother who is willing to provide a warm and comfortable home and give him the kind of support that he probably could use very well and which is not available in the hospital. This support may not be available at a future time.
>
> A combination of circumstances,I think, indicates that it would be against his psychiatric interests to be retained in the Hospital at all, let alone in the John Howard Pavilion. (Tr. 59-60)

The doctor added that the self-esteem appellant has developed and the efforts he has made over the past five years would be threatened if appellant were not released at this time. (Tr. 59)

In concluding that appellant is ready to leave the Hospital, Dr. Kaufman noted that there is a stable home into which he can go upon his release. (Tr. 55, Pet. Ex. 1, Recommendation for Conditional Release, December 8, 1969) His brother, Lantham Jones, is married and has a family and a steady job. He is enthusiastic about welcoming appellant into his family, and they have discussed his situation with

him extensively. (Tr. 55-56) As appellant testified:

> I explained to them...[his brother and sister-in-law] that I wanted them to be sure as I was and certain people was... that it was time for me to get out of the hospital. I told them I wanted them to be sure...to realize that what my charge was and what I was in the hospital for, and I wanted them to be sure before they made up their minds completely to accepting me...they told me they was. (Tr. 121-22)

The availability of this household after release makes this an optimal time for appellant's release. (Tr. 59) Appellant, through his counsel, has agreed to abide by any reasonable conditions set by the Hospital and the court for his release. (Tr. 14, Pet Ex. 1, Recommendation for Conditional Release, December 8, 1969)

Dr. Daniel Pugh, another psychiatrist on the Hospital staff, has opposed Dr. Kaufman's recommendation for release. (Tr. 167-68, 177-78) Although he agrees that appellant no longer suffers from schizophrenia, Dr. Pugh concluded shortly before the hearing in District Court that appellant has two other mental illnesses: chronic alcoholism (Tr. 162) and chronic brain syndrome. (Tr. 162-64) The mental illnesses detected by Dr. Pugh in October and December, 1969, respectively, (Tr. 189-90) had not been diagnosed during appellant's previous ten years in the Hospital. These diagnoses are not supported by the presence of the traditional symptoms, (Tr. 38-39, 40-42, 191-92) nor by the results of psychological tests given to appellant to detect the presence of brain syndrome. (Tr. 165-66)

Dr. Pugh testified that "further observation" of appellant was needed and that appellant must have five years of exemplary behavior before appellant can even be considered for transfer out of John Howard. (Tr. 184-85) Since Dr. Pugh believed that appellant committed forcible rape on his girl friend in May, 1967, he calculated the running of the five-year period from that date. (Tr. 179, 184) Confinement for three more years, while appellant is "observed" was Dr. Pugh's only suggestion for treatment. (Tr. 184, 194)

At the time of the hearing, according to Dr. Kaufman, appellant was receiving no treatment at the Hospital. (Tr. 57) He testified that appellant "is just remaining in his room and making do as he can." (Tr. 57) The Hospital had not developed an individualized treatment plan for appellant; the "periodic treatment review" of July 30, 1969, noted in the space for treatment plan: "Patient's recommendation for transfer disapproved." It did not contain any suggestion of a plan for treatment. (Tr. 58, Pet. Ex. 1, Periodic Treatment Review, July 30, 1969) Dr. Pugh testified that confinement in John Howard, in itself, was appropriate and necessary treatment for appellant. (Tr. 170, 176) In John Howard, he said, appellant could be kept under "observation" until the doctor felt that he would no longer be likely to be dangerous. (Tr. 184, 194, 204)

Proceedings Below

A hearing was held in District Court on December 22-23, 1969, before Judge Matthews. On January 29, 1970, the judge dismissed the petition and discharged the writ, signing the Hospital's suggested findings of fact and law verbatim.

Four issues presented to the District Court were, on motion of the appellee, ruled not properly before the Court. Appellant also appeals from the District Court's order, entered on January 28, 1970, holding that these matters were not before the Court.*/

ARGUMENT

I. PETITION IS ENTITLED TO BE RELEASED FROM ST. ELIZABETHS HOSPITAL.

Appellant contends that he is entitled to his release and that appellee is arbitrarily and capriciously detaining him; specifically he contends that he is no longer dangerous by reason of mental illness; that his initial commitment pursuant to D.C. Code §24-301(d) violated rights protected by statute and the Constitution; that he is improperly confined since he is no longer suffering from the mental illness that justified his initial commitment; and that he has not received adequate treatment. Appellant has, however, consented to any reasonable conditions imposed by the Hospital following his release. (Tr. 14)

*/ Appellant contends that these matters were all fully aired in the hearing, and are ripe for consideration in this Court.

A. Appellant is no longer likely to injure himself or other persons due to mental illness.

Appellant contends that he is not likely to be a danger to himself or others by reason of mental illness. Hence, he is entitled to his release.[2/]

The specific issue before the District Court was whether appellant was, at the time of the hearing "likely to injure himself or other persons because of mental illness." Dixon v. Jacobs, No. 23,378, order filed February 5, 1970, opinion issued April 10, 1970 (D.C. Cir.) Slip opin. p.13; Bolton v. Harris, 130 U.S.App.D.C. 1, 395 F.2d 642, 653 (D.C. Cir. 1968) Yet the District Court made no findings on this critical question. The court's Findings of Fact and Order,

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2/ Although appellant contends that he has shown by a preponderance of the evidence that he is not likely to be a danger to himself or others by reason of a mental illness, he submits that appellee, under the unusual circumstances of this case, has the burden of proving that appellant is presently a danger by reason of mental illness. In his Return to the Order to Show Cause, dated October 6, 1969, appellee Superintendent stated that continued confinement was justified by the fact that appellant suffered from "Schizophrenic Reaction, Chronic Undifferentiated Type." At the hearing, appellee shifted his ground and, in substance, abandoned this contention. Appellee's principal witness, Dr. Pugh, freely conceded that appellant did not suffer from schizophrenia. He alleged that appellant was suffering from radically different illnesses--alcoholism and chronic brain damage.

Appellant submits that an indigent mental patient cannot be put to the burden of disproving that he suffers from each and every mental illness in the Diagnostic Manual. If the appellee is going to raise allegations about new mental illnesses, appellee has the burden of proving that the patient suffers from such newly-discovered mental illness.

which were signed in precisely the form submitted by appellee, betray a misunderstanding of the standard applicable on Habeas Corpus. The court's Finding No. 8 suggests that appellant had the burden of proving that he would not be dangerous if released--whether or not such danger was related to mental illness. This is clearly erroneous.[3/] The court's Finding No. 5 indicates another misapprehension--that appellant had the burden of proving that the appellee had been "arbitrary and capricious" in failing to release him. Since the District Court's consideration of the case was colored by the application of these erroneous standards, the court's conclusion that the appellant is legally in custody is rendered suspect.

The evidence presented at the hearing clearly established that appellant was not likely to injure himself or others by reason of mental illness. Dr. Harold Kaufman, a staff psychiatrist at the Hospital who was appellant's ward administrator until ten days before the hearing testified that appellant was not suffering from any mental illness (Tr. 42), that he was not dangerous (Tr. 35-37), and that he should be released from the Hospital. (Tr. 33-37) Appellant is, at the present time, optimistic about his prospects outside the

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3/ This court has held that "the dangerous propensities must be related to or arise out of an abnormal condition" if confinement is to be justified. Overholser v. O'Beirne, 112 U.S.App.D.C. 267, 302 F.2d 852 (1962); Overholser v. Leach, 103 U.S.App.D.C. 289, 257 F.2d 667 (1958).

Hospital, and he has a suitable place to go. (Tr. 99-102) Dr. Kaufman stated that further hospitalization would impair his mental condition and make his eventual adjustment to the community more difficult. (Tr. 59-60) Dr. Kaufman noted appellant's record of good behavior while in the Hospital and his unusual drive for self-improvement. (Tr. 46, 59, 65) Appellant placed in evidence appellant's Hospital records which reflect a consistent pattern of good behavior over several years. (Pet. Ex. 1)

As noted, Dr. Kaufman stated his opinion that appellant is free from mental illness. (Tr. 42) There is no disagreement among Hospital staff that appellant is now free from schizophrenia, the mental illness that justified his initial commitment. The two Hospital psychiatrists who testified at the hearing categorically stated that appellant was not suffering from schizophrenia in any form. (Tr. 37, 163)[4/]

Dr. Daniel Pugh, a physician at John Howard Pavilion called by the appellee, while he agreed that appellant is no

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4/ The Superintendent, in his Return to the Order to Show Cause, ¶3, affirmed that appellant was still suffering from schizophrenia. But the Hospital staff repudiated this position at the hearing.

Only Dr. Edward Kirby, a Legal Psychiatric Service doctor who interviewed appellant once, thought that he was still suffering from schizophrenia. He admitted, however, that the disease was in remission, that is, that "the symptoms are not present at the moment...." (Tr. 146) Appellant submits that this judgment, based on a single hurried interview, is outweighed by the opinion of the Hospital staff.

longer suffering from schizophrenia, introduced on the witness stand the novel theory that appellant was suffering from two other "mental illnesses": chronic alcoholism and chronic brain syndrome. With regard to alcoholism, the underlying evidence for the diagnosis was notably weak. (Tr. 38, 171, 192) According to the American Psychiatric Association Diagnostic Manual, the diagnosis of alcoholism rests on a recent history of overindulgence in alcohol.[5/] Appellant has been in John Howard, where alcohol is not available, since May 1967. In the five months before his transfer to John Howard, during which time appellant had access to alcohol, he took an occasional drink, but never became a chronic user dependent on alcohol. (Tr. 38-39, 191-92) Since the alcoholism diagnosis is based on inferences from observation of repeated and continual use of alcohol (Diagnostic Manual, Tr. 45, 38-39) this diagnosis in reference to appellant rests on pure speculation.[6/]

5/ Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Association, p.45, (hereinafter cited as Diagnostic Manual.)

6/ In the event that the court concludes that appellant is an alcoholic, appellant submits that he is entitled, nonetheless, to his release. To hold that an alcoholic can be civily committed for an indefinite term would deprive him of the equal protection of the laws, Cf. Millard v. Harris, 132 U.S. App.D.C. 146, 406 F.2d 964 (D.C. Cir. 1968); Cross v. Harris, No. 22,420 (D.C. Cir. April 16, 1969). (Commitment as a sex psychopath of a person who could be civilly committed deprives him of equal protection of the laws.)

Dr. Kaufman stated his categorical conclusion that appellant was not an alcoholic. (Tr. 38-39)

Dr. Pugh's other suggested diagnosis, that appellant suffers from chronic brain syndrome, is equally insubstantial. (Tr. 164-65) When he first suspected the presence of chronic brain syndrome, Dr. Pugh ordered psychological tests to verify his hypothesis. The results of the psychological tests, which are specifically designed to detect chronic brain disorder, showed no evidence of chronic brain syndrome.[7/]

Dr. Kaufman interviewed the appellant to form an opinion on whether he had chronic brain syndrome, and concluded that appellant did not have chronic brain syndrome. He testified that appellant did not manifest any of the characteristic symptoms associated with that disorder. (Tr. 40-42) He further stated that appellant's outstanding educational achievements were inconsistent with chronic brain syndrome. (Tr. 45-46)

Dr. Pugh rested his diagnosis of chronic brain syndrome largely on appellant's disorientation and poor memory during an interview on October 18, 1969. This was "the clincher" according to Dr. Pugh. (Tr. 164) But Dr. Pugh admitted on cross-examination that appellant's record contained no similar instances of such disorientation or

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7/ Appellee's other psychiatric witness, Dr. Edward Kirby, rejected Dr. Pugh's speculative new diagnoses. (Tr. 144-45)

memory loss. (Tr. 199) Dr. Pugh further conceded that appellant had expected to be transferred out of John Howard at the time of this intereview on the strength of a different doctor's recommendation. Dr. Pugh told appellant at that time that he would not be transferred, knowing that he would be very upset by this information. (Tr. 198)

Appellant urges the Court to read appellant's testimony at the hearing. (Tr. 116-140) It is cogent and thoughtful, and it shows a strikingly good grasp of past events. What is more, it shows self-control and dignity under high-pressure cross-examination. (Tr. 126-37) This testimony in itself negatives the diagnosis of chronic brain syndrome.

The weight of the evidence, in sum, establishes that appellant is free of mental illness. All the staff doctors agree that he no longer suffers from schizophrenia; there is no factual basis for a diagnosis of alcoholism, and the evidence is inadequate to support a diagnosis of chronic brain syndrome.

The evidence that appellant would be dangerous by reason of mental illness is even weaker. This Court's words in Covington v. Harris must be borne in mind, in connection with the evaluation of the dangerousness determination:

> "Unless muzzled by discriminating analysis, it [dangerousness] is likely to weigh against nominally competing considerations the way a wolf weighs against a sheep in the same scales: even if the sheep is heavier when weighed separately, somehow the wolf always prevails when the two are weighed together....

> "Moreover, once a man has shown himself to be dangerous, it is all but impossible for him to prove the negative that he is no longer a menace....
>
> * * * *
>
> "In these circumstances it is fair to ask the Hospital how appellant can ever demonstrate his readiness for a less pervasive confinement: What evidence of improvement are they looking for? What is the prospect that they will ever find it?" Covington v. Harris, 419 F.2d 617, 627, 628 (D.C.Cir. 1969).

This process has operated in this case; appellee continuously harks back to appellant's behavior more than a decade ago in order to show his current dangerousness or at least to color the Court's consideration of appellant's mental state and dangerousness at present. (Tr. 72-77, 168-70, 179-80) This is so despite the fact that appellant's ward administrator and members of the Hospital staff who have worked closely with him on the wards, in classes and occupational therapy have testified to a dramatic change and improvement in his attitude, actions, and motivation during the past five years. In addition, appellant has exhibited genuine remorse over the event which led to his commitment to the Hospital. (Tr. 132) To let tales of horror from the distant past cloud the Court's consideration of appellant's condition is to fall into the very trap against which this Court warned in Covington. See also Cross v. Harris, No. 22, 420 (D.C. Cir. April 16, 1969); Millard v. Harris, 132 U.S.App. D.C. 146, 151-53, 406 F.2d 964 (D.C. Cir. 1968); and Rouse v. Cameron, 125 U.S.App.D.C. 366, 373 F.2d 451 (D.C. Cir. 1966).

Neither did appellee present evidence that appellant would be likely to be dangerous to himself or others because of his mental condition. Dr. Pugh testified that appellant has been on an "excellent course" (Tr. 178) for the past two and a half years. Dr. Pugh's concern with appellant's possible dangerousness rested almost entirely on his belief that appellant committed forcible rape on a fellow patient in May 1967. But, as we have noted, the Hospital had investigated the incident inadequately; and the only competent evidence offered at the hearing indicated that the incident involved an act of consensual intercourse. (Tr. 123) Dr. Pugh conceded on cross-examination that he would have to reassess appellant's case completely if appellant did not commit rape in 1967. (Tr. 184)

Yet, resting on this speculative information regarding the 1967 incident, Dr. Pugh formulated his "five year rule" for appellant. The appellant, according to this theory, cannot be considered for transfer out of John Howard until he has had a perfect conduct record for five years. (Tr. 179) This arbitrary rule, which leaves appellant's mental condition completely out of the equation, is psychiatrically indefensible; it suggests instead a benighted approach to penology.

Dr. Pugh gave no testimony at the hearing as to whether appellant's "dangerousness" arises from or is caused by appellant's present mental condition.

It should be noted, finally, in this connection that appellant has stipulated that he will accept any reasonable conditions imposed by the Hospital. (Tr. 14, Pet. Ex. 1, Recommendation for Conditional Release, December 8, 1969) His brother's home, where he will reside upon his release, is close to St. Elizabeths Hospital, and appellant could readily return for outpatient supervision. (Tr. 37) The criteria formulated by the Court for unconditional release should, therefore, be applied less rigidly.

B. Since Appellant Is No Longer Suffering from the Mental Illness Which Justified His Commitment Under §24-301(d) He Is Entitled to Release

Appellant was committed to St. Elizabeths Hospital by order of the United States District Court in 1963, pursuant to D.C. Code §24-301(d), having been found not guilty by reason of insanity on two counts of carnal knowledge and sodomy. Prior to his trial on these counts, psychiatrists at St. Elizabeths diagnosed appellant as suffering from schizophrenic reaction, chronic undifferentiated type, and stated their opinion that his alleged crime was a product of this mental illness.

At his habeas corpus hearing below, the staff physicians who examined appellant unanimously agreed that appellant is no longer suffering from schizophrenia. Appellant contends that this shift in expert opinion requires

his release. If the Hospital staff believes that appellant now suffers from some other mental illness and as a result is likely to be dangerous, appropriate re-commitment procedures must be instituted. Statutory commitment procedures--both civil and criminal--require a judicial determination that the person to be committed suffers from a mental illness and as a result of such condition is likely to be dangerous. Any procedure which did not require a judicial determination would raise serious constitutional questions.[8/] Bolton v. Harris, 130 U.S.App.D.C. 1, 395 F.2d 642,(D.C. Cir. 1968).

An individual may not be committed to a mental institution solely on the basis of an expert's opinion. Rather, he must be committed pursuant to an informed judicial action determining whether he is dangerous by reason of mental illness. The court in its hearing must consider the opinions of psychiatrists:

> "The chief value of an expert's testimony in this field, as in all other fields, rests upon the material from which his opinion is fashioned and the reasoning by which he progresses from his material to his conclusion; in the explanation of the disease and its dynamics, that is how it occurred, developed and affected the mental and emotional processes of the defendant; it does not lie in his mere expression of conclusion." Carter v. U.S., 102 U.S.App.D.C. 227, 236, 252 F.2d 608, 617 (1957).

8/ Barry v. Hall, 68 U.S.App.D.C. 350, 98 F.2d 222 (D.C. Cir. 1938) at 225. "...confinement in a mental hospital is as full and effective a deprivation of personal liberty as is confinement in jail. The Fifth Amendment is applicable in the District of Columbia...; and it guarantees that no person shall be deprived of liberty without due process of law. Due process of law ...does necessitate an opportunity for a hearing and a defense."

The initial judicial commitment, based on a finding that a person suffers from a particular mental illness, justifies confinement only so long as that mental illness continues. When that mental illness is terminated, the patient must be released.

This conclusion is buttressed by D. C. Code § 21-548 which provides that a patient shall be released if "the conditions which justified the involuntary hospitalization of the patient no longer exist...." This Court's decision in Dixon v. Jacobs, No. 23,378 (D.C. Cir. opinion issued April 10, 1970), states that this provision applies to §301(d) patients as well as civilly committed patients. Slip opin., p. 14, n.31. Since the condition which justified appellant's involuntary hospitalization--schizophrenia--no longer exists, appellant is now entitled to his release. If the appellee believes that appellant should be re-committed because of some other mental illness, civil commitment proceedings may be instituted.

This case illustrates the risk of leaving to the experts the decision to continue to confine a patient who is no longer suffering from the mental illness which led to his commitment. Dr. Pugh concluded that appellant suffered from alcoholism, which he apparently believed is a mental illness which justifies commitment. (Tr. 162) However, alcoholics

cannot constitutionally be civilly committed to St. Elizabeths Hospital.[9] The requirement of a judicial determination is necessary to avoid this kind of benevolently motivated misconstruction by psychiatric experts of the outer limits of their authority.[10]

This Court, in the recent case of Dixon v. Jacobs, supra, slip opin. p. 8, n. 17, forcefully outlined the reasons why a judicial determination is necessary before a decision can be made that a person's mental condition justifies commitment.

> "The presence of an abnormal mental condition, and the extent to which it impairs these processes and controls, are questions of fact: how "substantial" such an impairment must be to be considered a mental illness is a matter of law. The question of "dangerousness" is similarly mixed. The likelihood of future misconduct, the type of misconduct to be expected, and its probable frequency, are questions of fact; whether the expected

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9/ See footnote 6.

10/ Habeas corpus may not be deemed to provide an adequate substitute for a proper judicial proceeding in which the person seeking commitment has the burden of proving that the person is commitable. Bolton v. Harris, 395 F.2d at 649; Cameron v. Mullen, 128 U.S.App.D.C. 235, 387 F.2d 193, 201 (D.C. Cir. 1967).

> harm, and its apparent likelihood, are sufficiently great to warrant coercive intervention under our statutes are questions of law."

By allowing a psychiatrist, employed by the state, to retain control over an individual's liberty because he believes that the individual in question is suffering from a mental illness, even though that same psychiatrist agrees that the individual is no longer suffering from the mental illness that justified his original commitment, is to allow the psychiatrist to carry out a judicial function.

This is not to say that a new judicial proceeding is required every time there is a minor adjustment in a committed mental patient's diagnosis. But this case involves no small change in diagnosis. Appellant was originally diagnosed as suffering from a psychosis, schizophrenia. He is now alleged to have either a personality disorder--alcoholism--or an organic brain syndrome. The etiology, symptoms, treatment, and prognosis for these diseases are radically different.

The primary symptoms of schizophrenia are: (1) affective disturbance (flatness of affect, lack of an outward display of emotion); (2) looseness of association; (3) autism; and (4) ambivalence. The main accessory symptoms are delusions, hallucinations, and ideas of reference.[11/] Thought, mood, and behavior are all affected by the disease; there is a misinterpretation of reality (which may result in delusions or

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11/ Eaton and Peterson, Psychiatry at 226-28.

hallucinations). Mood changes lead to ambivalent and inappropriate emotional responses. Behavior may be withdrawn, regressive and bizarre.[12] The diagnosis, chronic undifferentiated schizophrenia is "for patients who show mixed schizophrenic symptoms and who present definite schizophrenic thought, affect and behavior not classifiable under the other types of schizophrenia."[13]

While schizophrenic symptoms involve many facets of functioning, the symptoms of organic or chronic brain syndrome are connected almost entirely with thought and intellectual functioning. The five main symptoms of chronic brain syndrome are: (1) impairment of orientation; (2) memory loss; (3) disorder of all intellectual functions such as comprehension, calculation, knowledge and learning; (4) faulty or impaired judgment; and (5) shallowness of affect.[14]

12/ Diagnostic Manual, p. 33

13/ Id. at 35

14/ Diagnostic Manual, p.22; Easton and Peterson at 309. It is interesting to note that contrary to the opinion offered by Dr. Pugh that chronic brain syndrome can be diagnosed by the presence of only impairment of orientation or impairment of memory (Tr. 163), the official manual of the American Psychiatric Association states that "most of the basic symptoms [of chronic brain syndrome] are generally present to some degree regardless of whether the syndrome is mild, moderate or severe." Diagnostic Manual, p. 22.

Alcoholism is a personality disorder which refers to patients whose alcohol intake is great enough to damage their physical health, or their personal and social functioning, or when it has become a prerequisite to normal functioning. Diagnostic Manual, p. 45.

The Diagnostic Manual makes it clear that the diagnosis of alcoholism is based on the current need for and daily intake of alcohol. Diagnostic Manual p. 45. Addiction to alcohol "should be diagnosed when there is direct or strong presumptive evidence that the patient is dependent on alcohol....The inability of the patient to go one day without drinking is presumptive evidence." Diagnostic Manual, p. 45. Since alcohol is not available in John Howard Pavilion, and appellant has not been on another service for two and a half years, it is difficult to see what relevance this diagnosis can have to his present mental condition.

In summary, since the Hospital staff has now concluded that appellant is no longer suffering from the psychosis which justified his initial commitment, appellant is entitled to be released. The appellee in his Return to the Order to Show Cause relied on appellant's schizophrenia to justify his continued confinement. Then he failed to prove that appellant suffers from this condition. If appellee wants to show that appellant now suffers from some previously undetected mental illness and that the danger associated with this mental illness

justifies commitment, he must follow the statutorily defined procedures for doing so.

C. Appellant Is Improperly Confined to St. Elizabeths Hospital Since There Has Never Been a Finding of Present Dangerousness By Reason of Mental Illness.

Appellant was committed to St. Elizabeths in 1963, having been found not guilty by reason of insanity to a charge of sodomy. (D.C. Code § 24-301(d)) This Court decided in Bolton v. Harris, 130 U.S.App.D.C. 1, 395 F.2d 642 (1968), that such a commitment, without a hearing on the defendant's present mental condition and dangerousness, is unlawful. Appellant was never afforded such a hearing; hence his commitment is illegal and he is entitled to release. Overholser v. Williams, 102 U.S.App.D.C. 248, 252 F.2d 629 (1958); Dooling v. Overholser, 100 U.S.App.D.C. 247, 248, 243 F.2d 825, 826 (1957); Barry v. Hall, 68 U.S.App.D.C. 350, 357, 98 F.2d 222, 229 (1938).

Appellant submits that the reasoning which the Court found persuasive in Bolton also requires a finding that appellant's continued confinement violates due process. In Bolton, the Court rested its decision in large part on the Supreme Court's holding in Specht v. Patterson, 386 U.S. 605 (1967). The Supreme Court in Specht dealt with commitment procedure under a state sex offenders act. The Court held that it was a denial of due process to commit a person under the act without affording him a hearing to present evidence and challenge the facts which allegedly justified his commitment.

In Cameron v. Mullen, 128 U.S.App.D.C. 235, 387 F.2d 193 (1967), this Court held that a defendant was deprived of due process when she was committed to St. Elizabeths without a hearing and full civil commitment safeguards after a not-guilty-by-reason-of-insanity verdict, where the defendant had not herself interposed the insanity defense. In Bolton, the Court held that the same principle applied, whether or not it was the defendant who interposed the insanity defense. 395 F.2d at 647, 649. The failure to hold a hearing on appellant's present mental condition and dangerousness at the time that he was committed for an indefinite term to St. Elizabeths likewise denied appellant his right to due process.

Appellant further submits that the Bolton holding--which has been applied prospectively from February 16, 1968--must be applied to patients committed prior to that date and that failure to do so constitutes a denial to such patients of equal protection of the laws. The interests of justice call for the retroactive application of the Bolton decision; and no considerations of "administrative convenience" outweigh these interests. See Baxstrom v. Herold, 383 U.S. 108 (1966).

Prior to the Bolton decision, a person found not guilty by reason of insanity--a finding based on a reasonable doubt as to the defendant's sanity at the time of the offense--

was automatically committed to St. Elizabeths. D.C. Code § 24-301(d); 395 F.2d at 644. The Court in Bolton held that two fundamental departures in the § 301(d) commitment procedure are constitutionally required. First, a substantive determination has to be made that the defendent is mentally ill and dangerous at the time of commitment. Second, a procedure for making this determination which provides substantially the same safeguards as the civil commitment procedure has to be established. Thus Bolton dramatically changed both "the procedures and requirements for commitment." Id. at 649. Persons who would have been commitable prior to Bolton were not necessarily commitable afterward.

Appellant contends that the prospective application of so fundamental a change in substantive standards and procedural rights, going to the heart of the commitment process, deprives him of the equal protection of the laws. Bolling v. Sharpe, 347 U.S. 497 (1954) (equal protection guarantee applies to the federal government through the Fifth Amendment). To continue depriving appellant of his liberty without measuring the deprivation against the same substantive and procedural yardsticks as other persons committed under § 301(d) constitutes an unconstitutional discrimination against appellant. There is no rational basis for making such a distinction.

It has been only relatively recently that the courts have adopted the technique of prospective announcement of

constitutional principles. But this technique has never been applied in a context like this one. In Stovall v. Denno, 388 U.S. 296, 297 (1967), the Supreme Court indicated that a new constitutional rule could not be applied prospectively in cases in which "denial of the right must almost invariably deny a fair trial...." Prospective overruling is appropriate only when the Court concludes that the probabilities are small that a "condemned practice infects the integrity of the truth-determining process...." Id. at 298. Even then, a rule should be applied prospectively only if there has been heavy reliance on the old procedure and there would be major dislocations to the administration of justice because of retroactive application. Id. at 298-99.

The Bolton case changed the very rules of the game. Before Bolton, there was no requirement for a finding of present mental illness and dangerousness; and, of course, there was no requirement for a hearing on these questions. If Bolton is not applied to appellant, he is denied any hearing on these issues. The commitment procedure condemned in Bolton did not merely "infect the integrity" of the truth-determining process. It omitted the process altogether. The prior practice was certain to produce unreliable results.

The three cases cited by the Court in Bolton are no precedent for prospective announcement in this situation: Johnson v. New Jersey, 384 U.S. 719 (1968); Stovall v. Denno, 388 U.S. 293 (1967); and Tehan v. United States ex rel. Shott,

382 U.S. 406 (1966). There the Supreme Court applied constitutional rules of criminal procedure prospectively. But these cases all involved details of trial procedure which did not go to the core of the decision-making process.[15/]

The procedures and substantive standards required by the Bolton decision serve different purposes from those served in the decisions the Supreme Court has applied prospectively only, such as Johnson, Stovall and Tehan. And the purpose to guarantee that an individual will not be deprived of his liberty without a fair hearing on present mental condition and dangerousness is so central to the process of committing individuals to mental institutions that that principle ought to have been, and ought now to be, applied to all cases, without limitation.

It should be noted that the retroactive application of the Bolton criteria for § 301(d) commitments will not impose an insurmountable burden on the judicial system. Retroactive application of Bolton would require reconsideration of the commitment of St. Elizabeths' inmates committed prior to February 16, 1968. A legal commitment of the individuals involved could be obtained, where appropriate, by instituting

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15/ In Stovall and Tehan, the Supreme Court dealt with the exclusion of trial identifications and confessions where the defendants at the time of identification or confession were not represented by counsel. In Johnson the Court dealt with the prohibition of comment in a criminal trial on the defendant's failure to take the witness stand.

a civil commitment proceeding, or by instituting proceedings which would be "substantially similar" to the civil commitment procedure. Bolton v. Harris, 395 F.2d at 651. And the District Court has the authority to order continued confinement of patients for a reasonable period of time, before the new proceeding could be held. Bolton v. Harris, supra, 130 U.S.App.D.C. at 10, 395 F.2d at 651. Cf. Ragsdale v. Overholser, 108 U.S.App.D.C. 308, 281F.2d 943 (1960).

It may also be noted that the decision in Bolton was far from unexpected in light of prior decisions of this Court and the Supreme Court. See Lynch v. Overholser, 369 U.S. 705 (1962); Baxstrom v. Herold, 383 U.S. 108 (1966); Cameron v. Mullen, 128 U.S.App.D.C. 235, 387 F.2d 193 (1967); Cameron v. Fisher, 116 U.S.App.D.C. 9, 320 F.2d 731 (1963); Williams v. Overholser, 104 U.S.App.D.C. 18, 259 F.2d 175 (1958).

D. Appellant Has Been Denied His Right to Receive Adequate Treatment.

Even if the court concludes that appellant was suffering from a mental illness, he would be entitled to release from the Hospital on the ground that he is not receiving adequate treatment. Every committed patient in the Hospital has a statutory right to treatment. D.C. Code § 21-562, Rouse v. Cameron, 125 U.S.App.D.C. 366, 373 F.2d 451 (1966).

In Rouse the Court suggested standards for judging the legal adequacy of the treatment a patient is receiving. The treatment must be tailored to the particular needs of the individual involved, insofar as present medical opinion knows how to deal with those needs and problems. Expert opinion and the official manuals of psychiatric associations are possible sources of standards for treatment.

Appellant has not, and is not now receiving adequate treatment under this standard. In fact, as he and Dr. Kaufman testified, he is receiving no treatment at all. (Tr. 57, 136-37) He takes no medication, is not in psychotherapy, group or individual. Nor is continued confinement alone therapeutic for appellant. Dr. Kaufman testified that it would be detrimental to appellant's mental health to remain at the Hospital (Tr. 59) and that this is an optimal time, therapeutically, for appellant to be released. (Tr. 59-60).

Nor does Dr. Pugh, who feels that appellant should remain in the Hospital have any treatment plan outlined for him. On the Periodic Treatment Review of July 30, 1969, the only notation under the space for treatment plan was: "Patient's recommendation for transfer disapproved." Such a lack of current treatment and of any plan by the Hospital to offer treatment to appellant is certainly a violation of the mandate of D.C. Code §21-562.

The Court in Rouse laid out the factors to be weighed in deciding whether a patient who is not being treated is entitled to release or whether the Hospital will be given an

opportunity to develop an adequate program. Rouse, supra, 373 F.2d at 458. Under these criteria, the Hospital is not entitled to continue appellant's confinement and compound its failure to provide appellant with adequate treatment. Appellant is entitled to be released.

II. IF APPELLANT IS NOT ENTITLED TO BE RELEASED, HE IS IN ANY EVENT ENTITLED TO BE TRANSFERRED OUT OF JOHN HOWARD PAVILION.

Under the decision of the Court of Appeals in Covington v. Harris, 419 F.2d 617 (D.C. Cir. 1969), the Hospital has the burden of justifying to the Court its decision to detain a mental patient in the maximum security service. The Hospital may impose no greater restrictions on the patient than are necessary to meet the purposes of commitment--the treatment of the patient's mental illness and protection of the community.

Even if the Court should find that appellant is not entitled to release from the Hospital, the inquiry is not complete. Appellant contends that the Hospital is illegally detaining him in John Howard. Appellant's present confinement in John Howard is traceable to the Hospital's reaction to an incident which took place in 1967. The Hospital's procedures in transferring him to John Howard after this incident were constitutionally inadequate; and his confinement today grows out of the 1967 decision. Furthermore, John Howard is by any analysis an inappropriate place for appellant's continued confinement.

A. Appellant Is Now Detained in John Howard Pavilion Pursuant to an Unlawful Transfer in 1967.

Appellant was transferred out of John Howard Pavilion in December 1966. For five months he was in the Cruvant Division, a less secure service, where his good behavior and continued progress earned him gradually increasing privileges. On May 13, 1967, he took his girl friend--a patient in the service--to a secluded place on the Hospital grounds and had intercourse. (Tr. 124) Appellant stated at the time and testified under oath at the hearing that the girl consented. (Tr. 124) The girl became upset and a struggle ensued. She calmed down, and they went to the Hospital canteen and had coffee together. The girl then returned to her ward. (Tr. 125) Subsequently, the girl denied that she had consented. On the basis of her accusation, appellant was summarily returned to John Howard where he has been ever since. Despite his protests, the Hospital never conducted an investigation of the incident (Pet. Ex. 1, Note, Mary 14, 1967) and petitioner has never had an opportunity to confront the girl. In plain terms, the Hospital unofficially convicted Petitioner of rape without a hearing and sentenced him to a term in the Hospital's most prison-like facility.

From the standpoint of judicial review of the Hospital treatment of the incident, there are two distinct aspects to the Hospital's action in this matter. First, there is the

Hospital's determination of a disputed factual issue: what was the nature of the 1967 incident? Second, assuming a finding that the patient did force his girl friend to have intercourse, what changes should be made in his treatment program and conditions of confinement? As to the first determination, mental health professionals have no special competence, and procedures for the Hospital's making such decisions should be prescribed by the courts to accord with due process standards. As to the second determination, mental health professionals do have special competence, and their decisions, provided that they are based on an adequate analysis of all relevant factors, should be given due weight. Tribby v. Cameron, 126 U.S.App.D.C. 327, 379 F.2d 104 (D.C. Cir. 1967). Petitioner contends that the Hospital did not comply with due process in its ascertaining of the facts of the incident, and that it did not take all relevant factors into consideration in its decision to return him summarily to John Howard.

1. The Hospital's Determination of Disputed Facts

The summary transfer of appellant to John Howard Pavilion deprived him of his constitutional right to due process of law. The Hospital's handling of the incident reflects their cavalier disregard for procedural regularity in resolving factual disputes relating to patients. See Williams v. Jacobs, No. 23, 763, pending in this Court (patient transferred to maximum security service without hearing on the

unsubstantiated accusation of robbery by member of Hospital custodial staff).

The decision to transfer appellant to John Howard was made by his ward administrator as soon as she heard his girl friend's account of the incident of May 13, 1967. There was testimony at the hearing that the doctor was upset and angry at appellant for "taking advantage" of the girl and that she refused, before ordering transfer (or afterwards, either) to give him a chance to explain himself. (Tr. 91-92) The record is barren of mention of any formal review of the transfer decision (Tr. 92-93); though appellant requested an interview with the doctor who ordered his transfer (Tr. 127, 138), he was never granted one. Nor was he given an opportunity to confront the girl. (Tr. 138) 16/

16/ Appellant's testimony reveals more eloquently than anything else the total absence of due process of law in John Howard.

"If you were familiar with the chance that your request of seeing a doctor at John Howard Pavilion [has], you would know that I had no chance to make a request to anyone.

"You write letters to the doctors downstairs and most of them explain, ... 'if you write me a letter I will put it in the trash can. You have to go through your attendant.'" (Tr. 139)

The doctors do not feel that they have to respond, even informally, to a patient's desire to clarify the record, much less to comply with any regularized procedure for fact-finding. The idea that the patient has a right to explain himself when accused of misconduct that can lead to severe deprivation of liberty is completely alien to those who run John Howard.

For a decision of such importance--it has, to date, cost appellant three years of confinement under maximum security conditions-- to be made without adherence to minimal due process in determining the facts denies appellant his constitutional rights and leaves him subject to arbitrary exercise of the Hospital's power over his life and liberty. The Hospital context is only one of many in which a government agency, subject only to limited judicial review, is empowered to judge and "sentence" those in its control. Due process safeguards are required in such a situation--in part by the need to assure the accuracy of the facts on which the decision is based, and in part by the belief that fairness, regularity, and integrity should inhere in procedures by which governmental bodies make decisions that affect the freedom of those subject to their control.

The Supreme Court in Goldberg v. Kelly, 38 U.S.L.W. 4223, recently reviewed the elements of minimal due process which must be afforded before an administrative action which will have major adverse consequences on an individual is taken. The Court stressed the requirement of a hearing with rules of procedure which are "tailored to the capacity and circumstances of those who are to be heard." 38 U.S.L.W. at 4227. Where important issues of disputed fact are involved, the rights of confrontation and cross-examination are particularly critical. Appellant contends that the demands of "rudimentary due process" outlined in the Goldberg decision were improperly denied to

appellant and that his right to due process was thereby violated. See also Willner v. Committee on Character and Fitness, 373 U.S. 96 (1963), (denial of due process to deny admission to the Bar without holding a hearing with rights of confrontation and cross-examination); Greene v. McElroy, 360 U.S. 474 (1959), (government employee may not be dismissed without hearing with safeguards of confrontation and cross-examination); Dixon v. Alabama State Board of Education, 294 F.2d 150 (5th Cir.), cert. denied 368 U.S. 930 (1961), (due process requires that notice and a fair hearing be afforded before a student is expelled from a tax-supported college); Ruffin v. Housing Authority of New Orleans, 301 F.Supp. 251 (E.D. La. 1969), (tenant may not be evicted from public housing unless the housing authority complied with procedural due process standards).

In the prison context, which is analogous in many respects to hospital one, courts have discarded the "hands-off" doctrine, which left the prisoner subject to substantially unchecked and irregular discipline and control by the prison officials. Courts are now requiring that prison authorities develop internal procedures which meet due process standards for making the factual determinations which precede discipline and transfer to maximum security. Howard v. Smyth, 365 F.2d 428 (4th Cir. 1966), (prisoner cannot be summarily confined in maximum security unless he is found, consonant with due process procedures, to have violated prison regulations); Landman v.

Peyton, 370 F.2d 135 (4th Cir. 1966), (transfers and decision to keep prisoner in maximum security must be made in accordance with due process and not be left to unfettered discretion of guards); Talley v. Stephens, 247 F. Supp. 683 (E.D. Ark. 1965), (corporal punishment of prisoners enjoined until regulations were promulgated which governed the infliction of such punishment).

The standard for judicial review of Hospital decisions based on expert judgment was formulated by this Court in Tribby v. Cameron, 126 U.S.App.D.C. 326, 379 F.2d 104 (D.C. Cir. 1967). This standard, reiterated in Covington v. Harris, 419 F.2d 617 (D.C. Cir. 1969), provides for limited review of Hospital action and applies to expert psychiatric decisions. It is in that area that deference is due to the professional expertise of the doctors. It was not meant to shield from scrutiny arbitrariness in determining underlying facts, a process which does not bring psychiatric expertise into play. Nor was it meant to relieve the Hospital of the responsibility of establishing regular and fair procedures for decision-making. This Court has often, to no avail, urged the Hospital to establish such procedures. See, e.g., Rouse v. Cameron, supra.

Fact-finding is a prerequisite for decision-making in any adjudicatory situation; it must be done as thoroughly and fairly in a hospital as in any other setting. The Hospital has failed completely to follow fair procedures in this instance.

There can be no doubt that appellant's present confinement in John Howard is directly attributable to his assignment there in May, 1967. Were it not for that administrative decision, appellant would have continued on his course leading to release. Moreover, Dr. Pugh, the man responsible for appellant's continued confinement in John Howard, testified that his recommendations regarding appellant rested on his acceptance of the 1967 incident as a case of forcible rape. He conceded that he would have to reassess his plan of five years' confinement for appellant in John Howard if the disputed events were otherwise. (Tr. 183-84)

2. Psychiatric Considerations in the Transfer Decision

In Covington v. Harris, supra , the Court held that the Hospital has an obligation not to deprive a committed mental patient of his liberty to a greater extent than is necessary to meet the purposes of that commitment. This "principle of the least restrictive alternative" operates with regard to assignments within the Hospital and is particularly important when confinement of a patient under maximum security conditions is at issue. The Court emphasized that before a patient is placed in maximum security, the Hospital has the burden of establishing that no less restrictive facilities are suitable for him. The Hospital's judgment will be upheld if the record reveals that all relevant considerations have been weighed.

The record in this case reveals that all relevant considerations were not taken into account. Instead, the unwillingness of appellant's doctor to speak to him because of her anger and her haste in ordering transfer suggest a frame of mind in which a considered decision is highly unlikely. (Tr. 91) It appears from the record that appellant's assignment to John Howard was based, at least in part, on punitive motives. The record does not reveal that medical considerations were fully considered in the transfer decision. (Tr. 127-28) On the contrary, it appears that the impact on appellant's program of treatment was scarcely considered. (Tr. 93)

B. Appellant's Confinement in John Howard Is Not Justified by Treatment or Security Considerations

Over the past two years, a succession of psychiatrists who have dealt with appellant in John Howard have recommended his transfer or his release from the Hospital altogether. (See Appendices A through C) Their recommendations reveal a thorough familiarity with appellant's situation and a thoughtful consideration of all relevant factors. Appellant submits that their conclusion is correct. The record clearly shows that there is no treatment program for appellant in John Howard. Indeed, in July, 1969, the hospital record shows that John Howard has no treatment program for appellant; it concedes that he is only in John Howard because the superintendent had, without explanation, refused the most recent transfer

recommendation. (Pet. Ex. 1, Periodic Treatment Review, July 30, 1969)

What is more, the record establishes that Dr. Kaufman, his ward administrator, and those nursing and instructional personnel who knew him best all believe that appellant would not pose a threat of danger if he were transferred out of the service or even released. See Appendix C.

Dr. Kaufman testified that appellant's remaining in John Howard is actually detrimental to his mental health. (Tr. 59) As noted above (pp. 13-19), the weight of evidence clearly showed that appellant should be released from the Hospital. A fortiori, it follows that he should be transferred out of John Howard.

Only Dr. Pugh purported to justify appellant's continued detention in John Howard,on the basis of his "five-year rule." Dr. Pugh believes that appellant should be kept for observation in John Howard for five years before transfer is even considered. Any misconduct while in John Howard would start the five-year period running again. (Tr. 179) Appellant submits that this draconian principle is without foundation in psychiatric practice and controverts both the letter and spirit of this Court's Covington decision.

Procedure for Review of Recommendations by the Superintendent

The Hospital's own medical staff overwhelmingly favors transfer of appellant out of John Howard Pavilion.

Appellant was recommended for transfer out of that service twice in the last eighteen months. (See Appendices A and B, attached hereto.) At both times, the ward administrator and the supervising doctor concurred in the judgment that appellant should be transferred. (Tr. 184-86) Lengthy recommendations were written in both instances, assessing appellant's past offenses, his conduct in the hospital, and his probable future course. This is an instance of the Hospital staff's complying with its duty to keep records that show in sufficient detail the considerations which preceded a hospital recommendation or action. (D.C. Code § 21-562)

Both of these recommendations for transfer were denied by the superintendent of the hospital without explanation. Such action is a violation of the record-keeping duties of the hospital; it completely negates the value of the reports of the doctors in that it gives no indication of the point with which the superintendent disagreed or which he found insufficient to support the recommendations. There is no way for the court to know if all relevant factors were taken into consideration by the superintendent; or what factors,not present at the ward level, entered into the decision;or whether an impermissible reason, such as lack of space in other services, lay behind petitioner's continued confinement in John Howard. Appellant submits that this procedure deprives him of liberty without due process.

CONCLUSION

For the reasons set forth herein, appellant requests the Court to reverse the decision of the District Court and order his release from the custody of appellee forthwith. Appellant agrees to abide by such reasonable conditions, on release, as the appellee may impose.

In the event that his request for release from the custody of appellee is denied, appellant requests that he be transferred forthwith to some other service within the Hospital where the restrictions on appellant's liberties will be less pervasive and burdensome.

Respectfully submitted,

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Attorneys for Appellant

Date: May 13, 1970

Standard Form 507
Prescribed by GSA
FPMR (41 CFR) 101-11.4

80,388

* U.S. GOVERNMENT PRINTING OFFICE : 1961 O—577477

CLINICAL RECORD

Report on _____
or
Continuation of S. F. 507 Notes
(Strike out one line) (Specify type of examination or data)

(Sign and date)

July 20, 1968: Dr. Wilbur A. Hamman, Jr. - Medical Officer (Psychiatry)

RECOMMENDATION FOR CT-AID TRANSFER OFF SERVICE

This 26-year-old male was first admitted to the hospital in October 1959, by Court Order for observation. Diagnosis was made in conference as Schizophrenia Reaction, Catatonic Type, and he was considered incompetent. In August 1960, he was discharged as competent for trial. In October 1960, he was found not guilty by reason of insanity and was readmitted to the hospital. In April 1961, he was transferred to West Side Division. He was returned to John Howard shortly thereafter following a suicidal attempt. He was again transferred to West Side in May 1962. In August of that year, he allegedly raped his 12-year-old niece. Following this, he was interviewed and gave the history that he had been offered liquor by his sisters on the day of his elopement, and it was one of the daughters of the sisters who got raped. He did stand trial on these charges and was again found not guilty by reason of insanity and was sent back to the hospital. He was recommended for transfer off service in June 1966, and was subsequently transferred to C.T. 4-A in December 1966. His category was changed from Class "D" to Class "C" at that time. He appropriately made a satisfactory adjustment and was recommended for change to Class "D" category in April 1967. However, in May 1967, he was involved in the alleged rape of a female patient and was transferred back to John Howard Division. Reference is made to the progress note of Dr. Blatkin, dated May 24, 1967, and Dr. Szewinsky's recommendation, dated May 29, 1967. Upon his return to the John Howard Division he did well initially. However, on December 1, 1967, he became disturbed and assaultive on Ward-6 and was transferred to Ward-12. I should point out that at that time the atmosphere and resulting tension on Ward-6 was running extremely high. Quite a few patients were becoming upset since obtaining their transfer to Ward-12, and based on this and my interview with Mr. Jones shortly after his arrival on Ward-12, it is my feeling that the tension state on Ward-6 had much more to do with this incident than any pathology of Mr. Jones. Following his transfer to Ward-12, the patient has got along extremely well. He has been cooperative with patients and employees. He has participated in discussion groups, in ward activities and in ward details. He has been neither verbally or physically assaultive on any occasion. He is considered one of the more responsible and responsive patients on the ward. In view of the patient's behavior over the past six months it is recommended that he be transferred off service.

RECOMMENDED DIAGNOSIS: 295.90 SCHIZOPHRENIA, CHRONIC UNDIFFERENTIATED TYPE.

RECOMMENDATION: TRANSFER OFF SERVICE.

(Continue on reverse side)

(Print or type name of writer below entries; last name, first name, middle initial; grade; date; hospital or medical facility)

REGISTER NO. 80,388 | WARD NO. JHD

JONES Alton

REPORT ON _____ or CONTINUATION OF SOC Notes

Saint Elizabeths Hospital

Standard Form 507
507-101

Standard Form 507
(Revised August 1951)
Department of the Navy
Circular A-102

80,383

* U.S. GOVERNMENT PRINTING OFF CE : 1951 O—[illegible]

CLINICAL RECORD

Report on _____
or
Continuation of S. F. 507 Notes
(Strike out one line) (Specify type of examination or data)

(Sign and date)

(Continuation of Recommendation For Diagnosis And Transfer Off Service, dated 7/29/68.)

William Hammon
Medical Officer (Psychiatry)

Linus D Weichbrodt
Acting Clinical Director

Remain in 6 months after major psychotropics (For transfers)

Archwood Ellis 8-20-68
Acting Superintendent

(Continue on reverse side)

Patient's name in CAPITALS (last name first; type or write entire last name—initials first. Middle: Grade; date; hospital or medical facility)

REGISTER NO. 80,383

WARD NO. JHD

JONES Alton

REPORT ON _____ or CONTINUATION OF 507 Notes

Standard Form 507
507-104

Saint Elizabeths Hospital

Federal Form 88
Revised August 1959
GSA FPMR (41 CFR) 101-11.6

U.S. GOVERNMENT PRINTING OFFICE : 1961 O-577111

CLINICAL RECORD

Report on _____
or
Continuation of S. F. 507 Notes
(Strike out one line) (Specify type of exam, portion or date)

(Sign and date)

March 10, 1961: Dr. Wilbur A. Newman, Jr. - Medical Officer (Psychiatry)
lcc
RECOMMENDATION FOR DISCHARGE OR SERVICE

This 46-year-old male was readmitted to this Hospital on October 1960, after having been found not guilty by reason of insanity. He had previously been admitted to the Hospital for observation in October 1959. At that time he was charged with Unauthorized Use Of A Motor Vehicle and Assault On A Police Officer. He was seen in Medical Staff Conference in December 1959, and was diagnosed as suffering from a Schizophrenic Reaction, Catatonic Type and was considered incompetent for trial. In June 1960, he was recommended for discharge and considered competent. He was discharged in August 1960, found not guilty by reason of insanity and then returned to the hospital. In April 1961, he was transferred out of John Howard Division to West Side Division. However, after an elopement, he was returned to John Howard where he remained until May 1962, at which time he was again transferred to the West Side Division. In August 1962, he eloped again from the hospital and it was reported that he had had intercourse with his 12-year-old niece during the night of August 10, 1962. He did not return to the hospital until April 1963, and at that time was here for 90 day's observation. He was seen in Medical Staff Conference in July 1963, and at that time expressed shame, embarrassment and disgust. He denied any recollection of having performed the acts on the niece. He also pointed out, and this was verified, that his sister had given him something to drink prior to this occurrence. Amnesia for these events was a distinct possibility. He stood trial and was found not guilty by reason of insanity and returned to the Hospital. By the Fall of 1964, he had enrolled in the Educational Rehabilitation Program and the director of this program felt that his efforts were sincere toward self-improvement. It was the opinion of those working with him, that his relationships with other patients had improved considerably, he showed very little hostility and various frustrations did not bother him as they had in the past. In view of the efforts which he had made and in view of his behavior on the ward, he was transferred off service from John Howard on December 20, 1965. On May 29, 1967, he was transferred back to John Howard. It was learned that on the afternoon of May 23, 1967, a female patient had returned to the ward crying, stating that she had been raped by Alton Jones. She stated that he had led her into the woods and proceeded to rape her. When interviewed, Mr. Jones readily agreed that he had relations with the patient, but stated that she was willing. However, he states that subsequently she became angry and slapped him and started to scratch and assault him and he had to hold her away from him, resulting in some superficial bruises.

Upon his return to John Howard Division he became active in the ward group meetings and seemed to be genuinely participating rather than manipulating as he did and do some of the members. He has been involved in occupational

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(Name, hospital or local facility)

REGISTER NO. 80,383 WARD NO.

NAME Alton Jones

REPORT ON _____ of CONTINUATION of S.F. 507

Saint Elizabeths Hospital

Standard Form 507
Jan 1961

80,328

U S GOVERNMENT PRINTING OFFICE : 1961 O—574679

CLINICAL RECORD

Report on _____

or

Continuation of S. F. 507 Notes

(Strike out one line) (Specify type of examination or data)

(Sign and date)

therapy and spends a fair amount of time reading and writing. He has a typewriter, which he learned to use, and apparently spends time writing short stories which he is trying to sell. The attendants feel that he is genuinely concerned in improving his educational status especially in terms of the use of English. Furthermore, he has helped several other patients with their homework and taught one young patient to type.

Psychologicals were obtained and were completed in January 1964. The psychologists states that he appears to be less retarded and autistic in his thinking and behavior than in previous evaluations, but seems more evasive and constricted than indicated in the last evaluation.

His behavior on the ward has been excellent in terms of cooperating with attendants and patients, in terms of his general demeanor, in terms of his attitude and in terms of the constructive nature of the activities in which he is involved, that is, he remains aloof from the cliques where manipulation and power struggle seems to be the prime objective. He definitely wants to be transferred off service and seems to have been working very hard toward this goal for some time now. In view of the above it is recommended that he be transferred off service.

DIAGNOSIS: 295.90 SCHIZOPHRENIA, CHRONIC UNDIFFERENTIATED TYPE.

RECOMMENDATION: TRANSFER OFF SERVICE.

William Hammann
Medical Officer (Psychiatry)

W. McPartlin
Acting Clinical Director

NOTE: This Recommendation for Transfer off Service on this patient is hereby disapproved. We do not consider him to be safe.

_____
Superintendent

A. Ahuja
Superintendent

(Continue on reverse side)

(Patient's Surname (last) (first or given name) (middle name or initial); date; hospital or medical facility)

REGISTER NO. 80,328 | WARD NO. 3JD

James Alton

REPORT ON _____ or CONTINUATION OF SCT Notes

Saint Elizabeths Hospital

Standard Form 507
507-104

CLINICAL RECORD

Report on _____
or
Continuation of S. F. 507 Notes
(Strike out one line) (Specify type of examination or data)

(Sign and date)

December 8, 1969: Dr. Harold Kaufman - Medical Officer (Psychiatry)
JK

RECOMMENDATION FOR CONDITIONAL RELEASE

In his note of October 18, 1969, Dr. Pugh states the following: "In conclusion I believe that Mr. Jones is not suffering from schizophrenia, but rather yet from chronic alcoholism. I believe that there is a distinct possibility that he might have a chronic brain syndrome and for that reason I will initiate psychological testing before I will come to a definite conclusion on that particular matter." I concur from an examination performed on Mr. Jones on December 7, 1969, that Mr. Jones does not at this time have schizophrenia. It is very difficult to determine whether he has chronic alcoholism, although at one time during his life by his own admission he had an alcoholic problem, which he states he had overcome at the time of admission to the Saint Elizabeths Hospital. With the respect to the issue of chronic brain syndrome my examination revealed the following: "There was no evidence of memory loss. Mr. Jones was able to recount in order and with accurac the Presidents from Franklin Roosevelt through Richard Nixon. He was accurate in giving the variety of dates about recent events. He was able to give the date of his earliest conviction. He was also accurate in performing serial 7's, although twice he had to correct himself. He was able to give an accurate answer to the date of President Kennedy's death. In an early part of the interview, I told Mr. Jo that he would be asked to remember three words, snow, ashtray and automobile. After speaking to him for 15 minutes I asked him what words I had spoken to him for recall He recounted accurately, snow, ashtray and automobile. Since entering John Howard, Mr. Jones has learned to read and to write with moderate proficiency. He showed me an example of his poetry, which he has been writing recently, in the hope that a friend of his might put this poetry to music for the purpose of creating a song. The images used, though not of great literary merit, indicated a capacity to use language in an imaginative manner. Mr. Jones had only a third grade education. He has benefited greatly from the efforts that he has made here in improving the level of his verbal skills. He states that he came into the hospital, a man who felt that he had no place in the world to go, and who was not equipped to cope with the world. As a result of the self-education program and the program that was provided for him here, to help him, he states that he now feels that he can go out into the world with a sense of greater ability to cope and would enhance self-confidence. He has a brother with whom he can reside with upon leaving the hospital He, furthermore, states that he would be happy to conform to any restrictions that the hospital would place upon him while making such an adjustment outside the hospit The nursing attendants, who have known Mr. Jones, and the nurses agree with my asses ment that Mr. Jones is not now likely to be dangerous to himself or others. Mr. Jon is a 47-year-old man. The longer that he remains in the hospital, the less likely it is that he will be able to make, in view of his entering late middle age at this

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CLINICAL RECORD

Report on _____
or
Continuation of S. F. 507 Notes
(Strike out one line) (Specify type of examination)

(Sign and date)

time an adequate adaptation outside the hospital. Moreover, there is no indication that he is now suffering from a mental illness of sufficient gravity to warrant retention. He has not been on medication for psychiatric disturbance for at least two years. During that time he has had two or three difficult encounters with patie on his ward never resulting in violence. In view of the fact that the standard for release from the hospital is likelihood of dangerousness to himself or others, and in view of the unanimous conclusion of those who have known him best, that he is not dangerous, it would appear to me to be merely providing preventive detention on theoretical grounds that he might possibly be suffering from a chronic brain syndrom or chronic alcoholism without this definitively being able to be determined while in the hospital. In any event, even if he is suffering from these diseases, the hospit has no right to retain him if he is not likely to be dangerous to himself or to othe Mr. Jones is very well motivated at this time to leave the hospital. He wishes to reside with his brother and obtain a job in the community. The hospital will provi a program by which Mr. Jones can be followed on an outpatient basis with the appropriate degree of control. It is recommended that Mr. Jones be granted a conditional release with the conditions to be set by the hospital in order to maximize the possibility of successful adaptation after release is granted.

DIAGNOSIS: 303.90 OTHER ALCOHOLISM.

RECOMMENDATION: CONDITIONAL RELEASE.

Harold Kaufman, M.D.
Medical Officer (Psychiatry)

Chief, Treatment Service Branch

Acting Clinical Director

Acting Superintendent

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PATIENT'S IDENTIFICATION (For typed or written entries give: Name: last, first, middle; grade; date; hospital or medical facility)
JONES Alton

Saint Elizabeths Hospital

REGISTER NO. 80,388

WARD NO. JHP

REPORT ON _____ or CONTINUATION OF 507 Notes

Certificate of Service

I hereby certify that a copy of the foregoing brief has been served, by hand, on John Terry, Esquire, Assistant United States Attorney, at the United States Courthouse, Constitution Avenue and John Marshall Place, N.W., Washington, D.C., this 13th day of May, 1970.

Charles R. Halpern

United States Court of Appeals
for the District of Columbia Circuit

No. 24,010

ANTON A. JONES, APPELLANT

v.

LUTHER D. ROBINSON, M.D., ACTING SUPERINTENDENT, SAINT ELIZABETHS HOSPITAL, APPELLEE

Appeal from the United States District Court
for the District of Columbia

THOMAS A. FLANNERY,
United States Attorney.

[illegible],
[illegible]
Assistant United States Attorneys

F.C. No. 182-69

INDEX

TABLE OF CASES

OTHER REFERENCES

* Cases chiefly relied upon are marked by asterisks.

ISSUES PRESENTED*

In the opinion of appellee, the following issues are presented:

(1) Whether appellant has met his burden of showing that he is no longer suffering from danger productive mental illness.

(2) Whether a change in appellant's recorded diagnosis entitles him to release.

(3) Whether appellant had a statutory right to a judicial determination of his need for commitment.

(4) Whether the trial court's finding that appellant has received adequate treatment is supported by the record.

(5) Whether appellant's reconfinement in John Howard Pavilion was permissible and reasonable in view of the relevant information and within the broad range of the hospital's discretion.

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* This case has not previously been before this Court.

United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 24,010

ALTON A. JONES, APPELLANT

v.

LUTHER D. ROBINSON, M.D., ACTING SUPERINTENDENT, SAINT ELIZABETHS HOSPITAL, APPELLEE

Appeal from the United States District Court for the District of Columbia

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BRIEF FOR APPELLEE

COUNTERSTATEMENT OF THE CASE

By petition of September 22, 1969 (Habeas Corpus No. 199-69), appellant sought release from Saint Elizabeths Hospital or transfer from John Howard Pavilion. The petition was denied after hearing by District Judge Burnita Shelton Matthews on January 28, 1970. This appeal followed.

Pre-Hearing Facts

Alton A. Jones, appellant in the instant case, began his present stay at Saint Elizabeths Hospital on September 15, 1963, after having been found not guilty by reason of insanity of charges that he committed carnal knowledge and sodomy on his eleven-year-old niece.

Appellant's history reveals an exceedingly troubled and unfortunate way of life.[1] Born on October 18, 1922, he was the third eldest of sixteen siblings. His mother characterized him as always having seemed mad at the world as if someone were doing something to him. Possessed of a fourth-grade education, he was by the age of eighteen a weekend drinker. In 1939 he was charged with housebreaking and carrying a dangerous weapon, apparently committed to get money for his parents.

In 1943 he married. In 1944 and 1947 he apparently assaulted his wife, Cora, who was six years younger than he and had two out-of-wedlock children. In 1946 he was convicted of auto theft and carrying a dangerous weapon, and in 1950 he received a term of three years in Lorton for burning down his parents' home. From 1955 to December 1958 he was again in Lorton for auto theft.

Appellant was first admitted to Saint Elizabeths on October 9, 1959, for a sixty-day mental observation after he was charged with unauthorized use of a vehicle and assault on a police officer. A medical staff conference on December 3, 1959, indicated a diagnosis of schizophrenic reaction, catatonic type. He was discharged to the United States Marshal on August 2, 1960, as "improved" and able to stand trial. His second and current admission began on October 3, 1960, when he was found not guilty by reason of insanity on the unauthorized use and assault charges.

Assigned at first to John Howard Pavilion, appellant was transferred to the West Side Service on April 3, 1961. His privileges were increased on April 24, 1961 to full ground, accompanied work and amusement privileges. On July 5, 1961, appellant was returned intoxicated from an elopement committed on May 18, 1961. Appellant's stay at West Side was terminated on October 11, 1961, after his nearly successful attempt to commit suicide by drowning in a bathtub.

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[1] Extracted from Saint Elizabeths Clinical Records dated July 25, 1962, March 2, 1967, May 18, 1967 and July 29, 1968. The records are contained in Petitioner's Exhibit No. 1 in the District Court.

Again, on May 2, 1962, appellant was transferred from John Howard to West Side, and his privileges on May 31, 1962, were increased. Appellant's response was a second elopement on July 3, 1962. He was returned by the police the next day from his sister's house, and on July 25, 1962, his privileges were restored.

In August 1962 he again eloped and was apprehended in Montello, New York, on January 10, 1963. On August 18, 1962, appellant had committed the offenses against his niece, mentioned above. Appellant claimed that he had had amnesia for the time of the assault on his wife in 1947, the house burning in 1958 and the sodomy. He remained in John Howard until he was transferred to Cruvant Service on December 20, 1966. His privileges were gradually increased during the spring of 1967, despite another unauthorized leave in January.

On May 13, 1967, appellant had intercourse with a twenty-seven-year-old idiot (with an I.Q. of 36) which she reported as rape. Appellant was returned to John Howard Pavilion on that date, and after an investigation of the incident the transfer was made permanent on May 29, 1967. Since that time appellant, with one clear exception in December 1967, has not been involved in any reported incidents of violence. Described as a good patient, he is presently lodged in a privileged ward within John Howard.

The Hearing

In his habeas corpus petition appellant alleged that he had recovered his sanity and would no longer pose a danger to himself or the public if released and that the Director of Saint Elizabeths acted arbitrarily and capriciously in refusing to certfy his release. Appellant requested alternatively (1) unconditional discharge, (2) conditional release or (3) transfer from John Howard Pavilion.

At the hearing before District Judge Burnita Shelton Matthews on December 22 and 23, 1969, appellant's counsel made an opening statement in which the above issues

were framed. However, appellant's counsel added four issues[2] that had not been raised by the petition (Tr. 14-18). Appellee objected vigorously and at length about appellant's raising issues outside the pleadings (Tr. 19-29), and the judge deferred ruling on those points until after the testimony was completed (Tr. 29).

Dr. Harold Kaufman, a staff psychiatrist at Saint Elizabeths, testified for appellant that based on his supervision of appellant, a review of his record and a communication with Lantham Jones, appellant's brother, he had recommended appellant's conditional release from Saint Elizabeths (Tr. 31-33). Dr. Kaufman stated that appellant, if residing with his brother and continuing on medication, would not, in his opinion, pose a danger to himself or the community (Tr. 35-36). That view of appellant was based primarily on his contact with appellant, especially during December 1969, and his record of stability since 1965 (Tr. 47). Dr. Kaufman dismissed the rape incident in May 1967 because, he claimed, appellant had never been able to testify to anyone that he might not have committed that act (Tr. 50-51). On cross-examination, however, he did admit that appellant in fact gave his version of the episode to two different persons, Drs. Platkin and Strawinsky, during the course of the investigation (Tr. 80). Although he admitted that he had not reviewed the events surrounding the house-burning and unauthorized use in 1959, Dr. Kaufman adhered to his claim that appellant was without mental illness (Tr. 72-74).

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[2] (a) Whether petitioner must be afforded a civil commitment proceeding under the Hospitalization of the Mentally Ill Act of 1964, 21 D.C. Code §§ 501-591, if the diagnosis of his mental illness changes, even though he is still considered dangerously mentally ill;

(b) Whether alcoholism may be considered a mental illness for purposes of civil commitment;

(c) Whether hospital authorities made an adequate inquiry into petitioner's sexual episode in May 1967; and

(d) Whether petitioner was improperly returned to John Howard in May 1967.

Jean Niedermeyer, who was employed as a social worker for appellant's counsel, testified that she had made a one-hour study of Mr. and Mrs. Lantham Jones, their home and the stability of their relationship. She concluded that it would be a good environment for appellant to move into (Tr. 86-87).

Lantham Jones testified that both he and his wife worked and they had eight children (including five girls) between the ages of three and eleven and were buying their own five-bedroom home. He further stated that he had one whole room for an extra adult (Tr. 99-100).

Appellant took the stand and explained that his behavior had improved in recent years and that his alleged rape victim, Rosie Adams, had consented (Tr. 117-119). Thereafter he explained, much as he had to Dr. Platkin in May 1967, how it was that Rosie had come to be bruised. He claimed that she was startled by the experience and became irate. They exchanged slaps and the "little lady was trying to bite [him] down there [apparently the genital area]." He then stated that he bit her. Thereafter the pair went to the canteen for coffee (Tr. 123-124). Appellant felt that he had had a full chance to explain the incident to Dr. Platkin and Dr. Baughman (Tr. 129). Later he stated that he had never requested to have a face-to-face meeting with Rosie (Tr. 139).

Dr. Edward C. Kirby, a psychiatrist for Legal Psychiatric Services, testified that he had examined appellant and his rather thick file. He stated that in his opinion appellant was suffering from a mental illness, schizophrenia, chronic undifferentiated type, but he added that he did not see the diagnosis as the important thing here (Tr. 143-146). According to Dr. Kirby, appellant had difficulty in controlling his symptoms, and impulsive behavior might cause him to be dangerous to the community. In fact, he thought the chances of a recurrence of his behavior would be great without graduated, increasing freedom in a controlled setting (Tr. 146-148). In response to questions on cross-examination he noted that appellant had had marks on his face from a recent alter-

cation at the time of his examination in 1969. In referring to the reported rape in 1967, Dr. Kirby felt that regardless of the version accepted, there was a beating involved (Tr. 155). He concluded that "being in a maximum security facility has minimized the number of stresses on [appellant], and this is the purpose—to help gain some control over a person's impulses, and maximum security has done that." (Tr. 146).

Dr. Daniel Duncan Pugh, a staff psychiatrist at Saint Elizabeths Hospital testified that appellant was suffering from chronic brain syndrome for which he detailed the symptoms, particularly emphasizing appellant's fluctuating instances of memory impairment (Tr. 162-165). He explained that as a behavioral phenomenon organic brain damage need not be present, nor need positive results be found on psychological tests for chronic brain syndrome to be diagnosed. Dr. Pugh further testified that he felt appellant would be likely to injure himself or others if transferred out of John Howard (Tr. 166-167). With regard to the alternatives to treatment in John Howard and to the type of treatment afforded appellant, Dr. Pugh testified that he had considered the possibility of placing appellant on a less restricted service, but in his opinion, maximum security would be more beneficial for appellant (Tr. 173-177). Dr. Pugh stated that he felt that appellant should stay in John Howard for a period in excess of his longest previous period of time without incidents of violence (Tr. 178-179).

On cross-examination Dr. Pugh explained that he took the 1967 rape incident into consideration in evaluating appellant. He felt that the physical evidence, as recorded, fairly indicated that forcible intercourse had taken place (Tr. 182). Later Dr. Pugh testified that his diagnosis of chronic brain syndrome, although stated in the record, was not officially recommended (Tr. 189). He further stated that confinement in a locked ward on Cruvant Service would not be so beneficial for appellant's condition as retaining him at John Howard (Tr. 194-195).

After the parties had filed memoranda directed to the question of whether the issues first raised orally at the hearing (see footnote 1, *supra*) should be considered, the District Judge, by order of January 23, 1970, ruled that those issues were not before the court. The rulings were primarily based on the issues not having been raised in the pleadings, appellee's specific objections to their consideration and appellant's failure to move to amend his pleadings to raise the issues. On January 28, 1970, the District Judge found that appellant was suffering from a mental illness and would be likely to injure himself or others if allowed to go at liberty. She further found that his reconfinement in John Howard in 1967 was a reasonable exercise of the hospital's discretion, that his continued detention there was the least restrictive within the purposes of his commitment, and that he was receiving treatment adequate for his condition. The writ was accordingly discharged.

ARGUMENT

I. Appellant is not entitled to be released from Saint Elizabeths Hospital.

A. *Appellant has not met his burden of showing that he is no longer suffering from danger-productive mental illness.*

In her order of January 28, 1970, the District Judge ruled that appellant had the burden of showing that his detention was illegal and found that appellant had not shown that appellee had been arbitrary or capricious in declining to release him as free of a mental illness rendering him likely to injure himself or others if released. Appellee submits that both the ruling and the finding were proper.

It is well settled that the burden of proof rests on the petitioner in a habeas corpus proceeding to show his detention to be illegal. *Johnson* v. *Zerbst*, 304 U.S. 458 (1938); *Bolton* v. *Harris*, 130 U.S. App. D.C. 1, 395 F.2d 642 (1968). Feeling that the decisions in this jurisdic-

tion, because of the recent importation of civil commitment procedures into commitments after a finding of not guilty by reason of insanity, might have left unclear who had the burden of proof, this Court explained in *Bolton* that "the court must find, by the preponderance of the evidence, that the patient's commitment is no longer valid." 130 U.S. App. D.C. at 12, 395 F.2d at 653 (1968). See also *Dixon* v. *Jacobs*, D.C. Cir. No. 23,378, decided February 5, 1970, slip op. at 13; *Collins* v. *Cameron*, 126 U.S. App. D.C. 306, 377 F.2d 945 (1967). Thus appellant's contention that the burden of proof was erroneously thrust upon him is unsupportable.[3]

Appellant relies on the testimony of Dr. Kaufman and his own optimism about his post-release prospects to meet his burden of showing by a preponderance of the evidence that he is entitled to be released. Dr. Kaufman, appellant's staff doctor for approximately one and one-half months at the time of the hearing, testified that he thought appellant had no mental disease, although he did state that appellant had been mentally ill in the past (Tr. 42, 69). However, he did not wish to change the diagnosis listed for appellant, apparently in December 1969, because he was not going to be able to observe him over a period of time (Tr. 64). Furthermore, Dr. Kaufman limited his confidence in appellant's prospective behavior to a recommendation for conditional release only (Tr. 35-37). In evaluating appellant's behavior since 1964, Dr. Kaufman declined to accept the version of the 1967 sexual incident as an example of violent behavior. On cross-examination Dr. Kaufman revealed that he had not reviewed appellant's memory loss in earlier years, despite the fact that he controverted the possibility of chronic brain syndrome for which memory loss is a significant diagnostic factor (Tr. 72).

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[3] Appellant claims that a change in his diagnosis should shift the burden. This contention rests on his allegation that a new mental illness was put forth by appellee. However, an examination of the record shows that the same mental illness has been found and treated throughout appellant's commitment.

Dr. Kirby, on the contrary, was of the opinion that appellant suffered from schizophrenic reaction, chronic undifferentiated type, which was in remission (Tr. 143-146). He was inclined to add that alcoholic factors appeared to be present (Tr. 151). Dr. Pugh corroborated Dr. Kirby's detection of mental illness but differed with him on its diagnosis. He stated that he had found indications of alcoholism coupled with chronic brain syndrome. In arriving at the latter diagnosis he made a comprehensive review of appellant's past behavior, his inability to recall significant events and his performance at two interviews conducted in October 1969. He explained that that syndrome is best diagnosed by interviews and a patient's general behavior and not by his performance on tests (Tr. 162-165, 167). Contrary to appellant's allegations both Dr. Kirby and Dr. Pugh were definite in their testimony that appellant would be dangerous if released into the community (Tr. 146-147, 167-168). Dr. Kirby even felt that "it would be a disservice to him to release him abruptly into the community" (Tr. 149).

Appellant suggests that by reviewing his history appellee has "let tales of horror from the distant past cloud the Court's consideration" of his condition (Br. 17). Appellee feels constrained to point out that appellant's course in his ten years at Saint Elizabeths is significantly different from that encountered in *Covington* v. *Harris*, —— U.S. App. D.C. ——, 419 F.2d 617 (1969). There the petitioner had been confined continuously in maximum security for ten years. A review of appellant's record indicates he has been given ample opportunity to prove himself with unfortunate consequences.

Two of the three psychiatrists who testified found appellant to be mentally ill to such extent that he would be dangerous to himself and others. The third, Dr. Kaufman, was unwilling to recommend unconditional release, and his testimony reflected an incomplete consideration of appellant's behavior in arriving at a conditional release recommendation. In these circumstances appellee submits that appellant has not even approached his requisite

burden of proof by a preponderance of the evidence that he is entitled to be released.

B. *A change in appellant's recorded diagnosis does not entitle him to release.*

Appellant contends that despite testimony that he still suffers from *mental illness*, a change in his *diagnosis* warrants his release and, if necessary, a new commitment.

Appellee submits that this issue is not properly before this Court since it was not raised in the pleadings in the District Court. The first notice that appellant gave that he was offering this issue for consideration occurred on the first day of the hearing. Appellee objected, and the court deferred its ruling (Tr. 20, 29). The court ultimately ruled that this issue, as well as the others at footnote 2, *supra*, was not properly before the court. Appellant, who was represented by able and competent counsel, did not move to amend the petition.

In a habeas corpus proceeding amendment of a petition is permitted according to the rules applicable in civil actions. The Federal Rules of Civil Procedure provide for amendment at any time by leave of court, and leave is to be "freely given when justice so requires." F.R. Civ. P. 15(a). Since efficiency and fairness are served by resolving all of petitioner's claims in one hearing, liberal amendment is permitted. *Holiday* v. *Johnson*, 313 U.S. 342, 350 (1941). However, in the instant case appellant has not moved to amend, and since there can be no contention that appellant requires special assistance as would a *pro se* petitioner, *cf. Matthews* v. *Hardy*, —— U.S. App. D.C. ——, 420 F.2d 607 (1969), *cert. denied*, 397 U.S. 1010 (1970); *Whittaker* v. *Overholser*, 112 U.S. App. D.C. 66, 67, 299 F.2d 448, 449 (1962), appellant must be taken to have knowingly declined to amend.[4]

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[4] Appellee made a timely objection to appellant's attempt to inject the issues not in the pleading. Consequently there can be no contention that the issues were tried with the express or implied

Since the issue was not ruled on in the District Court, it is not ripe for appellate resolution.

Furthermore, even if this claim be considered, appellee suggests that it is without foundation. The statute and the case law in this jurisdiction makes it abundantly clear that the standard for commitment is not a particularly diagnosed type of mental illness but merely a mental illness which may be danger-productive.[5] Appellant's claim that the change in *diagnosis* from schizophrenic reaction, chronic undifferentiated type to chronic brain syndrome with alcoholism by Dr. Pugh overlooks the evidence that appellant still suffers from a *mental disease* (Tr. 162-165, 172-177). Moreover, Dr. Kirby retained the diagnosis of schizophrenia that appellant finds lacking.[6]

Since appellant failed to raise the issue in his pleadings and since a change in a particular diagnosis, as opposed to recovery from mental illness, does not warrant discharge, appellee submits that this contention is without substance.

C. *Appellant was not improperly denied a statutory right to a judicial determination of his need for commitment, and he is not entitled to one at this time.*

Appellant claims that his commitment in 1960 was illegal because he did not receive a hearing as required by *Bolton* v. *Harris*, *supra*.

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consent of the parties. *Cf. Hamilton* v. *Hunter*, 65 F. Supp. 319 (D. Kan. 1946), cited with approval in *Harris* v. *Nelson*, 394 U.S. 286, 294 n.5 (1969).

[5] 21 D.C. Code Code § 545(b) prescribes commitment when "the person is mentally ill . . . ." See also *Overholser* v. *O'Beirne*, 112 U.S. App. D.C. 267, 269-270, 302 F.2d 852, 854-855 (1961); *Overholser* v. *Leach*, 103 U.S. App. D.C. 289, 292, 257 F.2d 667, 670 (1958), *cert. denied*, 359 U.S. 1013 (1959).

[6] Appellant suggests that alcoholism is not a mental illness. Be that as it may, both the oral testimony by Dr. Pugh and Dr. Pugh's reports of October 15 and 18, 1969, couple alcoholism with chronic brain syndrome in his diagnosis of appellant's mental disease.

Appellee urges that this contention, made for the first time on appeal, be rejected. In dealing with the same issue, exposed in precisely the same manner, this Court stated: "Moreover, orderly judicial procedure normally precludes raising on appeal issues not reasonably within the scope of the question presented by a petition for habeas corpus. There is no reason to consider an exception to this rule in the instant case." *Covington* v. *Harris*, —— U.S. App. D.C. at ——, 419 F.2d at 629.

Furthermore, this issue has already been considered and resolved in *Bolton;* acceptance of appellant's position requires overturning the decision of the Court in that case that its effect be prospective only. *Bolton* v. *Harris*, *supra*, 130 U.S. App. D.C. at 12-13, 395 F.2d at 653-654; see *Stovall* v. *Denno*, 388 U.S. 293 (1967); *Johnson* v. *New Jersey*, 384 U.S. 719 (1966); *Tehan* v. *United States ex rel. Shott*, 382 U.S. 406 (1966).

Finally, the cases that appellant suggests require the retroactive application of *Bolton* differ significantly from the instant case. *Baxstrom* v. *Herold*, 383 U.S. 107 (1966), applied the procedures of a previously enacted civil commitment statute to a prisoner who was committed to a mental institution at the expiration of his criminal sentence. *Specht* v. *Patterson*, 386 U.S. 605 (1967), held that when a Colorado Sex Offenders Act was invoked the statute required a hearing to comport with due process. *Bolton* itself applied the procedures of the Hospitalization of the Mentally Ill Act of 1964 (21 D.C. Code §§ 546-548) to proceedings as part of the commitment process already established in 24 D.C. Code § 301. In each of those cases the procedural statute interpreted or read into the commitment statute had been enacted prior to the commitment appealed from. In the instant case, the statute sought to be applied, 21 D.C. Code §§ 546-548, had not even been enacted at the time of appellant's commitment, and his commitment conformed to due process at that time. Appellant does not suggest otherwise. Thus appellant's argument ultimately depends on what amounts to a retroactive application of an Act of Congress. In

the absence of any showing by appellant that Congress intended such a result, appellee submits that this contention must fail.

D. *The trial court's finding that appellant has received adequate treatment is supported by the record.*

Appellant asserts that every committed patient in Saint Elizabeths has a statutory right to treatment. See 21 D.C. Code § 562; *Rouse* v. *Cameron*, 125 U.S. App. D.C. 366, 373 F.2d 451 (1966). Appellee concurs in that proposition and contends that appellant has received adequate treatment.

Dr. Kirby testified that since appellant has shown that when given freedom he has not been able to handle it properly, he felt that appellant's being in a maximum security facility had helped him gain control over his impulses and had minimized the stresses (Tr. 146). Dr. Pugh explained that appellant should be kept in maximum security until he is improved and should then be moved to progressively less restricted services with more responsibility. He felt that it would be therapeutically inadvisable to transfer appellant from John Howard, and he added that appellant had access to more nursing assistants and rehabilitative facilities there (Tr. 174-177, 194).

Dr. Kaufman, although differing from Dr. Pugh on the beneficial effects of a continued stay at John Howard, claimed that appellant had improved to the point where Dr. Kaufman recommended conditional release. For most of that period of improvement appellant was at John Howard. Furthermore, Dr. Kaufman outlined part of the treatment programs, consisting of weekly therapy group meetings which appellant attended (Tr. 31).

Consequently, it appears that appellant has been receiving treatment which has been beneficial to him, at least to a limited extent.[7] Appellee suggests that his

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[7] The District Judge was furnished additional information as contemplated in *Rouse* v. *Cameron*, *supra*, 125 U.S. App. D.C. at 372, 373 F.2d at 457. See Appendix A, *infra*, p. 17.

treatment is adequate and well within the "bona fide effort" found in *Rouse* v. *Cameron*, *supra*, 125 U.S. App. D.C. at 371, 373 F.2d at 456. Appellant's contention to the contrary is refuted by the record.

II. The District Court's conclusion that appellant is legally detained in John Howard Pavilion is amply supported by the record.

A. Appellant's reconfinement in John Howard Pavilion was permissible and reasonable in view of the relevant information and within the broad range of the hospital's discretion.

The claim of appellant that *Covington* v. *Harris*, *supra*, places the burden on the Hospital of justifying his transfer to maximum security is erroneous. In *Covington* the Court agreed with the argument "that since the District Court implicitly found the hospital's decision 'permissible and reasonable,' and since this finding is not 'clearly erroneous,' there is no substantial issue for appellate determination." —— U.S. App. D.C. at ——, 419 F.2d at 621. See also *Tribby* v. *Cameron*, 126 U.S. App. D.C. 327, 379 F.2d 104 (1967). Of course, the exercise of that discretion must be predicated on "a record which gives assurance that its decision has been made 'in view of relevant information.'" *Covington*, *supra*, —— U.S. App. D.C. at ——, 419 F.2d at 621.

The characteristics of that record and the procedure for its compilation were illustrated in *Williams* v. *Robinson*, D.C. Cir. No. 23,763, decided June 15, 1970, slip op. at 6: "Where the action challenged rests upon the determination of a disputed issue of fact, it [the agency] must be able to point to procedures giving the individual affected a fair opportunity to challenge that determination, and providing reasonable assurance that the determination is correct [footnotes omitted]."

The reconfinement complained of here occurred on May 13, 1967, after Rosie Adams reported that appellant had raped her. Appellant was immediately transferred

to John Howard (Clinical Record: May 13, 1967: Dr. Reuben H. Dawson).[8] The next day Dr. Mauris M. Platkin interviewed appellant at some length and duly recorded the interview (Clinical Record: May 14, 1967: Dr. Mauris M. Platkin). Appellant stated that the intercourse was consensual, but that afterwards he slapped Rosie a few times. On May 16, 1967, a further investigation was conducted by the hospital's security force. On May 29, 1967, Dr. Elizabeth Strawinsky compiled her report which described in detail Rosie's physical condition after the incident and followed with a recommendation that appellant be transferred to John Howard. Contained in the report is her conclusion that from Rosie's physical condition the incident could not have happened as appellant had related it (Clinical Record, May 29, 1967: Dr. Elizabeth R. Strawinsky).

Although appellant at the habeas corpus hearing was given an opportunity to explain the incident, he merely reiterated what he had told Dr. Platkin. He stated that he got a chance to tell Dr. Platkin everything that happened. Thus appellant in the instant case received the reasonable opportunity to contest the allegations contemplated in *Williams*. Nothing further should be required for internal hospital decisions.

B. *The District Court's finding that appellant is properly confined in John Howard Pavilion is supported by the record.*

Appellant contends that because his treatment program is not fully spelled out he should be released from John Howard Pavilion. Appellee submits that the primary psychiatric reasons for retaining appellant in John Howard Pavilion are adequately discussed at pages 13-14, *supra*. Additionally, appellee contends that the appellant's treatment is noted adequately in the hospital records, *e.g.*, Clinical Record, March 10, 1969: Wilbur

[8] The relevant Clinical Records are included in Appendix B, *infra*, pp. 25-32.

Hamman, Jr., as well as explained at the hearing, *e.g.*, testimony of Dr. Pugh (Tr. 172-179) and Dr. Kaufman (Tr. 31).

Appellant claims that he was deprived of due process by the denial by the superintendent of the recommendation for his transfer from John Howard Pavilion. Appellee suggests that the thrust of *Williams* v. *Robinson*, goes to the adequacy of the records as a basis for decision-making. Since appellee contends that the records are adequate, and does not understand appellant to claim the contrary, except for the records upon which his 1967 transfer was based, the fact that the superintendent reviewed them before noting his decision should be sufficient to sustain his finding. Furthermore, appellee submits that the brief statement given for the superintendent's March 10, 1969, declining the recommendation ("We do not consider him to be safe.") is an adequate description of his reasoning when considered in the light of appellant's record.[9]

CONCLUSION

WHEREFORE, it is respectfully submitted that the judgment of the District Court should be affirmed.

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United States Attorney.

JOHN A. TERRY,
BRIAN W. SHAUGHNESSY,
Assistant United States Attorneys.

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[9] It should be noted that the scope of judicial review is more limited in matters of internal hospital administration. *Dixon* v. *Jacobs*, *supra*, slip op. at 12.

APPENDIX A

The Question of Adequacy of Treatment

A position statement by the American Psychiatric Association *

Introduction

In 1966 the United States Court of Appeals for the District of Columbia Circuit ruled in substance that a person who has been committed to a mental hospital following acquittal on a criminal charge has a constitutional right to receive "adequate" treatment and that the court has a right to determine whether the treatment rendered is, indeed, adequate. Because of the precedent-setting nature of the ruling and its potential implications for psychiatric care facilities, it seemed incumbent on the American Psychiatric Association to formulate a psychiatric position on the issue as a contribution to the dialogue which may be expected in the wake of the Court's decision. Accordingly, APA's President appointed Dr. Henry A. Davidson as Chairman, and Drs. Oscar Diamond, Dale C. Cameron, Elvin V. Semrad, Joseph J. Baker, and Bernard C. Glueck Jr. as members of the Task Force to draft a statement. Their statement was reviewed by the Executive Committee of the APA Council on February 6, 1967, and approved with minor editorial changes as follows:

STATEMENT

The definition of treatment and the appraisal of its adequacy are matters for medical determination. Final authority with respect to interpreting the law on the subject rests with the courts. In any case, such definition and appraisal should take into account these seven basic considerations:

* Approved by the Executive Committee of Council, February 6, 1967.

1. *The purpose of hospitalization and related treatment programs.*—(*e.g.*, The problem is to direct the patient to the proper facility. A long-term care facility differs in purpose from an intensive short-term treatment unit in a community general hospital.)

2. *The relevance of diagnostic procedures.*—(*e.g.*, Adequate diagnostic evaluation is an essential part of the total treatment process. The diagnostic and treatment plan must undergo constant revision as more knowledge is gained about the patient.)

3. *Protecting the patient.*—(*e.g.*, There is need to prevent suicide and self-injury and to prevent acts harmful to others so far as possible. It would manifestly, be "poor treatment" to release a patient to commit an unlawful act.)

4. *Interrupting the disease process.*—(*e.g.*, There is frequent need to cut the patient off from narcotics, drugs and medications that may befuddle or toxify him, to separate him from acute stress situations, and to supply pharmocologic, dietetic, surgical and other medical measures to prevent the worsening of his condition.)

5. *Physical methods of treatment.*—(*e.g.*, These include shock therapies, medication, treatment of incidental illness, and various somatic procedures.)

6. *Changing the emotional climate surrounding the patient.*—(*e.g.*, The challenge here involves readjusting the patient's total environmental milieu, helping him to a more realistic appraisal of himself, changing his attitudes, remotivating him, providing him with new and improved social and personal skills in living and relating to the society about him. Such modalities as occupational therapy, music therapy, participation in patient government, halfway house experience, and many others contribute to the readjustment.)

7. *Conventional psychological therapies.*—(*e.g.*, These include individual and group psychotherapies, pastoral counselling, social casework, and similar non-physical approaches to the patient designed to sharpen his understanding of both conscious and unconscious forces that

impinge on his behavior. Through abreactions, reassurance, suggestion, reeducation, persuasion, exhortation, guidance, depth psychotherapy, and similar techniques, efforts are made to construct modes of behavior that will at once satisfy the patient's psychological needs and society's demands.

These seven categories are not discrete. They overlap. It is neither possible nor desirable to force a categorization of any single program under any single rubric. Nor will any one patient profit from all of the procedures cited. It is the responsibility of the physician to determine the appropriate treatment techniques to fit the individual patient's physical and psychological needs, assets and circumstances. Further, this determination must be made realistically in relation to the facilities, personnel, and objectives of the institutions, clinics, or agencies that are at hand.

Still, subject to these qualifications, the seven categories will serve usefully as criteria against which the adequacy of treatment may be assessed. They are presented as of possible use to courts and other agencies confronted with the problem of determining legitimacy and adequacy of treatment.

Cooperation of the Patient

Any comprehensive treatment plan requires a degree of cooperation by the patient to be effective and some procedures incidental to the plan require more cooperation than others. It is possible, for example, to give patients electroshock and medication without cooperation, and this may be done in an effort to make the paaient more cooperative and receptive to other treatment procedures. Almost any form of conventional psychotherapy is extremely difficult to administer without cooperation and it may be said in general that the effectiveness of the psychotherapies is proportional to the degree of cooperation that is present. Some psychotherapies cannot be given at all without it. When cooperation is withheld the starting point of a treatment plan is to help the patient under-

stand his need and to lead him to a more cooperative attitude. If a patient will not (or more accurately cannot, because of the illness) cooperate, then it is neither obligatory nor sensible to attempt to force it upon him.

Perforce, the principle must be that a patient is entitled to any available treatment which will help him and and which he (and his family in some instances) will accept. Regardless of whether a patient's refusal of treatment is willful or a product of his illness, it does not follow that his demand for release can be met because he has not received a treatment which he has refused.

Bona Fides

The United States Court of Appeals for the District of Columbia (Rouse vs. Cameron) has stated: "The hospital need not show that the treatment will cure or improve the patient, but only that there is a *bona fide* effort to do so." We are in full accord with the principle. Failure of treatment is always possible, but it must always be provided in good faith.

Treatment and Punishment

The conceptual contrasting of "treatment" on the one hand with "punishment" on the other sometimes obfuscates more than it clarifies the problem. Some courts, attorneys, statutes and judicial formulations reiterate, almost ritualistically, that hospitalization without treatment equates with punishment. This is not precisely the case.

Involuntary hospitalization clearly does imply restraint and may be properly viewed as a kind of punishment in a simple, unqualified context. But if such hospitalization is part of a treatment program aimed at interrupting a disease process (even though the treatment is refused or fails) it is not useful to dub it punishment any more than it would be useful to view depriving an addict of the narcotic of his choice as punishment. The utilization of this kind of involuntary restraint may be viewed in one sense

as analogous to problems encountered in child-rearing wherein there are no sharp delineations as between guidance and discipline or between discipline and punishment, all of which are directed towards putting internal and external limitation on unacceptable behavior. Restraints may be imposed from within by reinforcing a patient's inner defenses or from without, by pharmacologic means or by locking the door of a ward. Either imposition may be a legitimate component of a treatment program. Only if a patient were restrained and did not receive any of the treatment cited above could the restraint properly be called punishment. Further, it is unsound to dismiss a procedure as "purely custodial" or "purely punishing" without assessing the total circumstances in which it has been prescribed. The procedure is often of therapeutic value.

Individualization of Treatment

A program that has therapeutic value for one patient may be of no benefit to another. Some patients, for example, manifest acute anxiety when placed in open ward; others panic when placed behind locked doors.

Dangerous Patients

On the basis of long experience, psychiatrists estimate that about 90 percent of all mental hospital patients are harmless and in no way threaten the community in which they reside. Admittedly, however, the other 10 percent comprise roughly 60,000 patients and protecting the community from irresponsible acts they might commit is a priority social concern. To release them prematurely is never justified regardless of the adequacy of treatment they may be receiving. The constructive way of approaching this problem lies in obtaining the staff and facilities for providing adequate treatment, not in premature release.

Alternate Dispositions

A mental hospital is not always the best possible facility for providing adequate treatment. At the same time it should be appreciated that it may not be in the interest of the mental patient, especially the confused, severely depressed or senile patient, to thrust him out of the hospital even though the treatment setting is not ideally suited to his needs. The point is, however, that all possibilities for securing adequate treatment should be explored—general hospitals, out-patient clinics, day treatment centers, private practitioners, halfway houses, nursing homes, and many others. Such exploration is the proper function of the family physician, the social agency, and the patient's family and not of the court or the hospital. If there are no such facilities then, of course, the mental hospital may be the best solution to meet the needs of patients and community, but referral to it should not be a matter of routine.

The Total Milieu

All parts of the environment surrounding a patient have impact upon him. The total effect of his overall milieu cannot be explained by analyzing each part of it separately. In one hospital ward setting all decisions may be made for him—when he will shave and shower, when and what he will look at on television, etc. In another ward situation general permissiveness may characterize the milieu. Either situation may have therapeutic or antitherapeutic effect on the disease process.

The Incurable Patient

The late Dr. Winfred Overholser, long-time superintendent of Saint Elizabeths Hospital in Washington, D.C., often reiterated: "I do not believe that we should write off any patient as incurable. We are going to try our hand at treating every patient who is sent to us." The profession of psychiatry must endorse this statement notwithstanding acknowledgment that its science cannot yet

prevent lifetime hospitalization for a few. One can only keep trying with the knowledge and skills at the profession's disposal and in the hope that research will be ever-productive of new knowledge that will make the effort more effective.

Staff Shortages

In general, there appears to be a positive relationship in mental hospitals between small size and larger staff-patient ratios and the rate of recovery of patients. That is, a mental hospital with more than 1000 beds and with 25 employees per hundred patients gets poorer results than a smaller hospital with 250 employees per hundred patients. The model "Draft Act" governing hospitalization of the mentally ill recognizes this in stating that "every patient is entitled to treatment to the extent that facilities and personnel are available." Some courts appear to reject this principle and say in effect that lack of staff is no excuse for failure to treat a patient, and that if ideal staff ratios cannot be maintained to provide adequate treatment then the patient should be released. We think this doctrine is tantamount to an oversimplified gospel of perfection. Clearly, in perspective of the overall mental health manpower shortage in our country, one must settle for something less until personnel shortages can be overcome.

The Ultimate Responsibility

The ultimate responsibility for the relative adequacy of psychiatric treatment facilities rests with the community. Day by day responsibility for operating and administering these facilities rests with a professional staff accountable to the community for its performance. The staff must respond to criticisms of its work from any responsible civic source. Nevertheless, the staff must have authority, day by day, to determine priorities in the use of personnel, to appraise patients' progress, and in all other ways have freedom to operate the facility in the best in-

terests of the total patient population. Mental hospital administrations may vary in quality as do all human institutions. It is one thing, however, for outside community agencies to render constructive criticism of the relative adequacy of a psychiatric facility, and quite another for it to interpose its judgments on the professional managerial affairs of that facility. The former must be welcomed. It it doubtful if the latter will enhance the quality of administration.

APPENDIX B

CLINICAL RECORD

Report on 507 Note

May 14, 1967: Dr. Mauris M. Platkin—Medical Officer (Psychiatry) PSC

I interviewed Mr. Jones today, because last evening he had been returned to John Howard Division from the Cruvant Service, after having been accused of raping a patient on the grounds.

I had been advised yesterday, by Dr. Strawinsky, that one of her patients, a mentally retarded woman of twenty-seven, had claimed that she had been raped by this patient. At the time of this complaint, Mr. Jones, who had nine o'clock ground privileges, was not to be found, and subsequently when he had not returned for dinner it was so reported to me, and he was placed on elopement status. However, he did return to his ward before nine o'clock and, accordingly, the elopement status was cancelled. He was brought to John Howard Division.

In my interview with Mr. Jones, he seemed quite disturbed at the turn of events. He stated that he had "been going" with this patient for several months, and that it was pretty generally known among all their mutual acquaintances on the grounds. He states that they had, on some previous occasions, done some moderate degree of petting, but nothing that involved a genital contact. He did state that he understood that she had never previously had sexual intercourse, and that he had broached the subject to her, stating that when a man and woman go together sexual relation is sooner or later assumed. However, he states at this time that he carefully and explicitly cautioned this woman carefully to think over his suggestion and not to commit herself to any act of sexual involvement, unless she was sure what she was doing.

Yesterday, she reported to Mr. Jones that she had discussed the matter with some of her fellow patients, who advised her that sooner or later she has got to grow up

and become a woman, and, accordingly, they had agreed, Mr. Jones and this patient, to have sexual intercourse. They went down the hill into a heavily grown area behind the Cruvant Service, where they then had sexual relations, into which she voluntarily entered. Mr. Jones states that he experienced no particular difficulty in making vaginal penetration, and that he believes she experienced orgasm as he did. He states that, following their sexual act, the patient noticed some blood on her and became quite disturbed and kicked and slapped at Mr. Jones. He in turn became upset and slapped her once, knocking her into the bushes. However, he immediately regretted this, picked her up, and they talked for some fifteen minutes, after which they went over to the canteen, had something to drink, and he returned her to the Service somewhere between 3:30 and 4:00 P. M. Afterwards, he left, sat near the first gate, and chatted with some fellow patients.

He is quite upset and indignant at the fact that he is charged with rape, stating that this is not the kind of thing a man does to a girl he goes with, and that, in any event, this was an act to which she voluntarily entered, and that he would not jeopardize the progress he was making with the possibility of Conditional Release in the near future by doing such a thing. He states he is at a loss to understand why he would be accused of raping the girl.

I advised Mr. Jones that the matter is being carefully investigated, and that I assumed he would appreciate the necessity of his being returned to John Howard pending the outcome of the investigation. I advised him that if, indeed, he were innocent of any wrongdoing, he would then be restored to his previous status.

/s/ Mauris M. Platkin
Medical Officer
(Psychiatry Supervisory)

JONES, Alton A.
Saint Elizabeths Hospital
Register No. 80,388—Ward No. JHD

CLINICAL RECORD

Continuation of S. F. 507 Notes

May 13, 1967: Dr. Reuben H. Dawson—Medical Officer (General Practice) LS

UNAUTHORIZED LEAVE AND RETURN

This D. C. Prisoner and patient was identified as the rapist of Rosie Adams, 88,470, a 27-year-old idiot (I.Q. 36). The act occurred around 3:45 p.m. He was placed on unauthorized leave by Dr. Strawinsky's orders and to be sent to John Howard Division on return. Disposition: Clinical Director, Dr. Cameron, Number 11 Precinct notified and Form 53 completed.

Hospital course: Born October 18, 1922. First admitted October 9, 1959, on a 60-day mental observation charged with Unauthorized Use of A Motor Vehicle and Assault on a Police Officer. Medical staff conference December 3, 1959, produced a diagnosis of Schizophrenic Reaction, Catatonic Type and condition on discharge as unimproved. He was discharged to U.S. Marshal August 2, 1960, as improved and able to stand trial. Second and current admission began October 3, 1960, when he was found not guilty by reason of insanity on the above charges. Recommended for transfer off service and transferred to West Side April 3, 1961. Recommended for accompanied work and amusement privileges with extension of full ground April 24, 1961. First unauthorized leave May 18, 1961. Returned by police intoxicated July 5, 1961. Attempted suicide (by trying to drown in bathtub) October 9, 1961. Recommended for transfer off service October 11, 1961. Transferred from West Side to John Howard Division October 11, 1961. Recommended for transfer off service March 24, 1962. Transferred from John Howard to West Side May 2, 1962. Recommended for accompanied work and amusement privileges May 31, 1962. Second unauthorized leave July 3, 1962, returned

at 5:30 a.m. July 4, 1962, by police from his sister's house. Recommended for restoration of accompanied work and amusement privileges July 25, 1962. Third unauthorized leave August 18, 1962. On August 18, 1962, committed a vicious rape of 11-year-old niece. Recommended for transfer off service September 14, 1962. Return to mechanism of Court by way of D.C. Jail on April 11, 1963, with charges of Carnal Knowledge and Sodomy. Subsequently sent to Court for second set of charges. Returned from visit as not guilty by reason of insanity on September 15, 1963. Recommended for transfer off service June 7, 1966, transferred from John Howard Cruvant 4-A December 20, 1966. Recommended for change in category from Class "B" to "C". Fourth unauthorized leave January 15, 1967, 11 p.m., returned voluntarily January 16, 1967, at 5 p.m. Recommended for Class "C" category March 2, 1967. Recommended for accompanied trips to Congress Heights Recreation Center to swim on February 20, 1967, March 21, 1967, and April 4, 1967.

Patient returned at 9:15 p.m. and was sent directly to John Howard Division Six . (6)

/s/ R. Dawson
Medical Officer
(General Practice)

JONES, Alton
Saint Elizabeths Hospital
Register No. 80,388—Ward No. BAC

88,470
80,388

May 16, 1967
Rosie Adams
Alton Jones

Charles A. Brenner
Captain, Security Force

Patient Reported Being Raped

On May 13, 1967, at 4:26 p.m., Officer Charles F. Beavers, who was on duty at No. 1 Gate, received a call from Mr. Joseph Henneberry, supervisor of Cruvant Division, who informed him that one of his patients had reported to him that she had been raped.

On investigation, Sergeants Carroll F. Thomas and Keith S. Lemon learned from Mr. Henneberry that at approximately 3:45 p.m. this date Patient Rosie Adams, 88470, a D.C. prisoner of Cruvant Division, Ward B, had returned to the service crying and very upset, and reported to him that she had been raped by Patient Alton Jones, 80388, a D.C. prisoner, also of Cruvant Division, Ward 4-A.

Patient Adams was seen by Dr. Elizabeth Strawinsky, Clinical Director of Cruvant Division, and ordered transferred to the W. W. Eldridge Building for examination. This incident was reported to Dr. Mauris Platkin, Clinical Director on duty, Miss Ruby Painter of the Nursing Service, Dr. Reuben Dawson, evening physician, and the Metropolitan Police.

Patient Alton Jones failed to return to the service for the evening meal and was placed on unauthorized leave at 5:50 p.m. This was the time when the Metropolitan Police were notified.

At approximately 7:08 p.m. Sergeant Thomas was able to talk with Patient Adams. She gave the following state-

ment: She was approached by Patient Jones outside of Cruvant Division, who she knew because he had bought different articles for her, such as a watch, a necklace, and other small items. She further stated that they walked over to John Howard Division and then to the wooded area in the rear of the building, and this is where he raped her, removing her pants, hitting her about the face and the mouth, and choking her around the neck. After the relationship, he walked her to the Nichols Building Canteen and bought her a cup of coffee, telling her he was sorry, then walking her to the front of Cruvant Division where she reported the incident.

At approximately 9:20 p.m. Officer Beavers received a call from Cruvant Division stating that Patient Jones had returned to his ward. Patient Jones was then questioned by Sergeant Thomas in regard to the incident and he stated that he did have relations with Patient Adams but it was not rape, she was willing, and he did slap her after she slapped him. He further stated that she informed him that he was the first person who had ever done anything like that to her.

Patient Alton Jones, at the request of Dr. Strawinsky, was then transported to John Howard Division by the Security Force where he was placed on Ward 6.

CLINICAL RECORD

Continuation of S. F. 507 Notes

May 29, 1967: Dr. Elizabeth R. Strawinsky (Clinical Director) LS

RECOMMENDATION FOR TRANSFER TO JOHN HOWARD DIVISION

While on duty in Cruvant Building on the afternoon of May 13, 1967, the supervisor indicated to me that Rosie Adams had returned to the building at approximately 3:45 p.m. crying, very upset and reporting that she had been raped by Patient Alton Jones, then with ground privileges from Cruvant A. Upon seeing Miss Adams, she explained to me that she had gone out on her ground privileges and been met by Mr. Jones and led into the woods where he proceeded to rape her, slap her, choke her, and bite her on the inner aspect of the left thigh. Her face was swollen and bruised, especially her lip, and her neck was reddened and bruised as if from fairly recent attempts at choking. There was what appeared to be a human bite on the inner aspect of the left thigh in which the skin was abraded but not entirely broken. Her wounds were cleansed and treated and she was sent to the Medical and Surgical Branch for evaluation of possible rape where vaginal abrasions were found with slight bleeding and cleansing measures were undertaken. Later, apparently after she returned to the building and indicated his gifts—many were aware that he had given her gifts—and the watch in question was sent to property in his name. Request was made that the grounds be searched for Mr. Jones: however, this was to no avail, and he did not return for the evening meal and was therefore placed on unauthorized leave and the Metropolitan police were notified as per routine. Shortly after 9 p.m., Mr. Jones returned to Cruvant and was interviewed by the supervisor in regard to Miss Adams, what she alleged and her condition. According to the

supervisor, Mr. Jones readily agreed that he had had relations with Miss Adams indicating that she was willing however, added that he slapped her after she had slapped him because it was her first heterosexual experience. This, of course, did not account for her other injuries, and he seemed absolutely unaware that Miss Adams could be mentally ill and incapable of dealing with whatever fate might come her way. Before leaving my duty at 5 o'clock, I made arrangements with Dr. Platkin, Acting Clinical Director, for Mr. Jones' transfer to John Howard Division if and when he was to be apprehended.

Under date of May 29, Mr. Jones addressed a letter to me which he intended to be an explanation of the whole affair. I will respond to the letter, and his letter as well as the usual copy will be filed in his A-Building chart.

Diagnosis: 22.5 Schizophrenic Reaction. Chronic Undifferentiated Type.

Recommendation: Transfer to John Howard Division.

/s/ Elizabeth Strawinsky
Clinical Director

/s/ Dale C. Cameron
Superintendent

JONES, Alton
Saint Elizabeths Hospital
Register No. 80,388—Ward No. BAC

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REPLY BRIEF FOR THE APPELLANT

IN THE

UNITED STATES COURT OF APPEALS

FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 24010

ALTON A. JONES, JR.,

APPELLANT,

v.

LUTHER D. ROBINSON, M.D., Acting Superintendent,
St. Elizabeths Hospital
Washington, D. C.,

APPELLEE.

APPEAL FROM THE DISCHARGE OF WRIT OF
HABEAS CORPUS BY THE UNITED STATES
DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

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v.

LUTHER D. ROBINSON, M.D., Acting Superintendent,
St. Elizabeths Hospital
Washington, D. C.,

APPELLEE.

REPLY BRIEF FOR THE APPELLANT

Introduction

In his main brief, Appellant argued that he was entitled to be released from St. Elizabeths Hospital (the "Hospital") or, at least, to be transferred out of John Howard Pavilion. No further arguments are necessary on

many of his points. Some further discussion is necessary, however, particularly since decisions of this Court issued since the felony of Appellant's brief materially buttress Appellant's claims to relief. Williams v. Robinson, No. 23.763 (D.C. Cir, June 19, 1970); Norwood v. Jacobs, No. 23,214 (D.C. Cir., July 24, 1970).

Before dealing with the substantive issues of the case, however, it is important to reply to Appellee's argument that this Court should disregard several of Appellant's contentions as not properly before the Court.

Issues Properly Before the Court

Seeking to avoid argument on the merits of certain issues in Appellant's case, Appellee strenulously argues the technical point that Appellant presented issues at the hearing without properly raising them in his pleadings.[1/] Appellant has three answers to this contention.

1. Appellant's broadly phrased habeas corpus petition was sufficient under Rule 8(a) of the Federal

1/ Appellee's summary of the issues which he wishes this Court to disregard appears on page 4, n. 2 of his brief.

Rules of Civil Procedure to encompass all of the issues raised at the hearing.

2. Each of the issues Appellee would exclude is essentially a question of law. At the hearing there was no dispute respecting the factual circumstances upon which each issue was based and all facts pertinent to the legal issues were fully developed.[2/]

3. At the hearing, Judge Matthews deferred ruling on what issues should be excluded until the completion of the hearing, and accepted all testimony proferred on each issue. Legal arguments on the several issues were fully presented for her analysis in appropriate post trial memoranda. The net effect of the District Court's ruling that the issues were not properly before that court, if upheld here, would be to require a completely new District Court hearing; yet in that new hearing the

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2/ Whether a radical change in the patient's diagnosis requires a recommitment hearing and whether alcoholism is a mental disease within the meaning of the pertinent statute involve nothing but issues of law. On the other two issues mentioned at page 4, n. 2 of Appellee's brief -- i.e., whether the Hospital authorities made adequate inquiry into the alleged incident of sexual assault in 1967 and whether Appellant's transfer that year to John Howard Pavilion was proper -- there was no dispute on the facts as presented by the Hospital's own records and the testimony. Thus, on these issues, the Court was asked to decide, in the light of undisputed facts, whether the Hospital's conduct was legally proper.

only evidence which would be brought forward by either side would be evidence already in this record. It would be hard to imagine a greater waste of judicial time than to require the repetition of an identical evidentiary hearing. Moreover, a remand to the District Court would be unjust to Appellant, who, during a further and wholly unnecessary evidentiary hearing, would remain confined under maximum security.

Appellant is Entitled to Immediate Release

1. Appellee attempts to support his contention that Appellant's incarceration should continue by picking and choosing among widely inconsistent medical opinions, based on the testimony of experts having varying degrees of familiarity with Appellant's medical condition. Even a cursory consideration of his argument exposes its insubstantial quality.

In his Return to the Order to Show Cause, Appellee contended that Appellant continues to suffer from a schizophrenic reaction, undifferentiated type. In the hearing, no member of Appellee's staff supported this contention. Appellant's Brief, p. 8. Dr. Kaufmann, a staff psychiatrist

at St. Elizabeths, who was Appellant's ward administrator until ten days before the hearing, testified that Appellant was no longer suffering from any mental illness at all, (Tr. 42), that he was not dangerous (Tr. 35-37), and that he should be released from St. Elizabeths (Tr. 33-37). Appellant's Brief, p. 12.

The only other Hospital staff member called to testify, Dr. Pugh, also stated that Appellant is free from a schizophrenic reaction. Dr. Pugh, who was Appellee's witness, did express the opinion that Appellant suffers from organic brain syndrome and alcoholism.[3/] The one witness at the hearing to testify that Appellant suffered from any form of schizophrenia was Dr. Kirby, a member of the Legal Psychiatric Services and not a member of the Hospital staff. On the basis of the Hospital records and one brief interview with Appellant,

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3/ Contrary to Appellee's contention, (Brief p. 8, n. 3) this belatedly arrived at opinion is not indicated in the Hospital records until immediately before the District Court's hearing. To arrive at a diagnosis of a patient the Hospital holds a staff conference at which are present several medical and psychological professionals who discuss the patient's record and arrive at a consensus on the diagnosis. The Hospital records indicate that such a staff conference has never resulted in a diagnosis consistent with Dr. Pugh's view.

Dr. Kirby testified that Appellant continues to have a schizophrenic reaction, undifferentiated type, but that he has at the present time no symptoms of disease -- the malady is, in Dr. Kirby's opinion, in "remission" and may not reappear for a long time, if ever. Tr. 144.

Contrary to Appellee's contentions, Dr. Kirby's view does not buttress Dr. Pugh's evaluation since organic brain syndrome and alcoholism are completely different in origin, cause and symptoms from all forms of schizophrenia. In fact, Dr. Pugh's and Dr. Kirby's testimony tend to rebut each other.

Because of the vague and inconsistent diagnoses offered by Drs. Pugh and Kirby, Appellee is forced ultimately to argue in his brief that it is unimportant what diagnosis is made of Appellant's condition. The whole question, Appellee claims, is whether there was "evidence that Appellant still suffers from a mental illness." Appellee's Brief, p. 11 (emphasis in the original). The ultimate result of this contention is that the courts ought to rely solely upon the conclusion by the Hospital staff and administration that an individual suffers from a mental illness, without evaluating the

analysis underlying that conclusion. As a matter of fact, Appellee contends that the disarray of opinions of the staff is irrelevant to the Court's consideration. Such contentions overlook the principles this Court adopted in Carter v. United States, 102 U.S. App. D.C. 227, 236, 252 F.2d 608, 617 (1957) (Appellant's Brief, p. 20):

> "The chief value of an expert's testimony in this field, as in all other fields, rests upon the material from which his opinion is fashioned and the reasoning by which he progresses from his material to his conclusion; in the explanation of the disease and its dynamics, that is how it occurred, developed and affected the mental and emotional processes of the defendant; it does not lie in his mere expression of conclusion."

Since the evidence presented in the habeas corpus hearing clearly establishes that Appellant is no longer suffering from a schizophrenic reaction and since his detention was founded on the clinical determination that he was a victim of that disorder, the reason for Appellant's detention has vanished and he has a right to immediate release.[4/]

4/ In making this contention, Appellant does not deny that in ordering his release, the Court may permit his continued incarceration for the purpose of a de novo commitment hearing by the Hospital on the basis of his new diagnosis. Presumably, however, the period of continued confinement should be brief, since the Hospital has already had ample opportunity to evaluate Appellant's condition. See Norwood v. Jacobs, supra.

On this issue, this case is closely analogous to Norwood v. Jacobs, supra. In Norwood, this Court held that a sexual psychopath who developed a mental illness while he was confined in the Hospital could not be confined as mentally ill without a civil commitment proceeding. Refusing to entrust the vital matter of the patient's continued confinement to psychiatric judgment alone, the Court in Norwood insisted on appropriate judicial consideration. A similar result is essential in this case.

2. Further, Appellee misapprehends Appellant's position that Bolton v. Harris, 130 U.S. App. D.C. 1, 395 F.2d 642 (1968), should be applied retroactively. Appellee's contention that "Appellant's argument ultimately depends upon what amounts to a retroactive enactment of an act of Congress" (Appellee's Brief, p. 12) is patently erroneous. True, the Bolton decision was based on an interpretation of the Mentally Ill Act of 1964. However, Appellant submits that the ultimate holding of Bolton is that an individual found not guilty of a crime by reason of insanity is entitled to essentially the same

opportunity for a hearing on his present mental condition as is accorded an individual involuntarily incarcerated pursuant to the civil commitment procedures. The application of this holding to patients like Appellant who were incarcerated before enactment of the Mentally Ill Act of 1964 would require that prior to commitment of such patient they be accorded a hearing analogous to the civil commitment procedure then in force. (See D.C. Code §§ 21-310-316 (1963 ed.). The reasons that led this Court to afford Mr. Bolton a hearing on his present mental condition are equally applicable to this Appellant. 5/

3. In his main brief, Appellant argues that he is entitled to release because he is receiving no treatment at the Hospital. Appellant's Brief, p. 31. On this issue Appellant calls the Court's attention to the decision in Williams v. Robinson, No. 23,763 (order filed June 15, 1970, D.C. Cir., opinion issued June 19, 1970). In Williams, the Court emphasized that the Hospital must have an adequate

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5/ For some reason, Appellee assumes that Appellant directs the Court's attention to D.C. Code §§ 21-546 to 548, the provision for periodic review of continued incarceration. Appellee's brief, p. 12. This is simply erroneous.

plan of treatment for each patient and that the Hospital's records must show on their face that this plan is being properly carried out. Nothing in Appellant's Hospital records, all of which have been submitted as exhibits in the District Court, remotely resembles a treatment plan. Ironically, what Appellee cites in his brief as embodying Appellant's treatment plan is actually a recommendation for Appellant's transfer out of John Howard Pavilion, a recommendation summarily rejected by Appellee. A recommendation for transfer out of John Howard can scarcely be regarded as a plan for continued treatment within John Howard. The most cursory examination of the document referred to by Appellee shows that it does not purport to set out any plan of treatment, much less that it conforms to Williams' requirement that the Hospital's plan "show the information upon which the Hospital relied in reaching its decision and explain the course of reasoning by which the result was reached." Slip op., p. 6. It should be noted that in the opinion of Dr. Kaufmann, further confinement of Appellant in John Howard would have a positively anti-therapeutic effect. Tr. 59.

If one turns from Appellee's brief to the testimony at the hearing, one finds nothing to allay the impression given by Appellee's brief that in reality, Appellee has nowhere provided Appellant with a plan of treatment worthy of the name.

Absence of Due Process in Appellant's Recommitment to John Howard.

Since the filing of Appellant's initial brief, this Court has addressed itself in its decision in Williams v. Robinson, supra, to the Hospital's obligation to provide fair procedures in determining disputed factual issues in regard to its patients. In Williams, as in the present case, the disputed facts concerned alleged criminal conduct by a patient who was in a position at the time of the alleged offense to move promptly towards release. The Court stated that:

> * * * in a matter as serious as this, elementary consideration of due process requires that, when a need for immediate action is past, Appellant be afforded some reasonable opportunity to test the evidence against him and present his side of the story. Slip op., p. 12.

As the Court had previously indicated in its decision in Dixon v. Jacobs, No. 23,378 (opinion issued April 10, 1970, Slip Op., p. 17), the procedures available to the patient must be within his competence to invoke.

Appellee suggests in his brief that the Hospital procedures in the present case were adequate under Williams because the Appellant had an opportunity to present his side of the case to a John Howard psychiatrist, Dr. Platkin. The fact is, however, that the decision whether to make the transfer was not within Dr. Platkin's responsibility. Moreover, the Hospital's records reveal that Dr. Platkin explicitly told Appellant that his interview with Appellant was only one step in an investigative process which would be undertaken to establish the true facts. Note of May 13, Appellee's Appendix B, p. 26. The Hospital records disclose no such further investigation.

Appellee also cites a note written by Dr. Strawinsky and dated May 29, 1967, some two weeks after the alleged incident. Dr. Strawinsky refers to Appellant's letter to

her concerning the incident and states that she would respond to his letter. However, neither Appellant's letter nor the promised response, if indeed a response exists, are part of the Hospital's files. Furthermore, the May 29 note does not reflect any further investigation by the Hospital. It appears that the Hospital could easily have given a fuller investigation of the incident, since it involved, inter alia, a visit by Appellant and his alleged victim to the Hospital canteen and their conversations at the canteen with other patients. The Hospital never took the trouble to check the facts.[6/] Yet the alleged assault, so cursorily looked into by the Hospital, was responsible for Appellant's transfer to John Howard Pavilion and his continued confinement there under maximum security for a period exceeding three years. Moreover, Dr. Pugh, the only Hospital psychiatrist to testify that he feels continued confinement is justified, admitted that he would change his opinion if, in fact, Appellant had not committed rape in 1967. Tr. 184.

6/ The Appellee, perhaps whimsically, suggests that Appellant "waived" his right to further contest the charges against him. In fact, Appellant's clear testimony establishes that the nature of John Howard procedures made it impossible for him to contact a doctor and to make such a request. Tr. 184.

Thus in Appellant's view the Hospital is presently confining him for alleged criminal conduct without the remotest semblance of fair procedure or of rudimentary due process.

In saying this, Appellant by no means contends that the Hospital should be held to the same strict standards of due process which govern the determination of criminal guilt. He does contend, however, that the Hospital is bound to undertake at least some modest investigation into readily ascertainable facts, rather than simply accepting at face value the testimony of a not necessarily reliable fellow patient of Appellant. Appellant also contends that where the Hospital promises an accused patient further investigation, it should fulfill this promise to the extent that this is feasible and that the patient should have an opportunity to express in writing to the Hospital staff further considerations in his favor which may occur to him after the initial shock of accusation.[7/] Admittedly, "the opportunity to be heard

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7/ Appellant's efforts to obtain for himself a full opportunity to defend himself were futile and frustrated. See Tr. 139.

must be tailored to the capacities and circumstances of those who are to be heard." Goldberg v. Kelly, 38 U.S.L.W. 4223, 4227 (decided March 23, 1970). But, some reasonable opportunity should have been afforded.

Conclusion

For the reasons set forth herein and in Appellant's main brief, Appellant respectfully requests the Court to reverse the decision of the District Court and order his release from the custody of Appellee forthwith. Appellant agrees to abide to such reasonable conditions upon release as the Appellee may impose.

Respectfully submitted,

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